Supreme Court, U. S.
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In the Supreme Court

of the United States

OCTOBER TERM, 1974

No. 74-1274

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent,

v.

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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Petitioners.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Petitioners pray for a writ of certiorari to review the judgment of the United States Court of

Appeals for the Ninth Circuit filed December 26, 1974.

OPINIONS BELOW

A copy of the oral opinion of the district court of May 25, 1973 granting petitioners' motion for partial summary judgment is attached as Appendix B, infra, A10. The court did not file a written opinion.

The opinion of the court of appeals of December 26, 1974, vacating the judgment of the district court is not yet reported. A copy is attached as Appendix A, infra, A1.

JURISDICTION

The judgment of the court of appeals was entered December 26, 1974. Petitioners filed a timely petition for rehearing and a suggestion for rehearing in banc, which was denied on March 11, 1975. A copy of the order denying the petition is attached as Appendix C, infra, A18. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

QUESTIONS PRESENTED

The Nonprofit Institutions Act, 15 U.S.C. § 13c, exempts from the Robinson-Patman Act purchases of supplies by nonprofit hospitals "for their own use." In its decision, the court of appeals held, as a matter of law, that the exemption extends only to purchases of pharmaceutical products by nonprofit hospitals

which are dispensed to hospitalized bed patients and to emergency room patients, and that purchases by such hospitals of drugs which are dispensed for other hospital functions are outside the scope of the exemption.

The question presented by the court's decision is whether drugs purchased by nonprofit hospitals are "for their own use" only if they are dispensed to hospitalized bed patients and to emergency room patients, and not if they are dispensed to registered patients treated at outpatient clinics, as "take home" drugs to departing bed patients, or to staff and employees.

STATUTES INVOLVED

1. Section 1 of the Robinson-Patman Act, 15 U.S.C. § 13(a), 49 Stat. 1526:

> "(a) It shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality, where either or any of the purchases involved in such discrimination are in commerce, where such commodities are sold for use, consumption, or resale within the United States or any Territory thereof or the District of Columbia or any insular possession or other place under the jurisdiction of the United States, and where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or

knowingly receives the benefit of such discrimination, or with customers of either of them. . . ."

2. The Nonprofit Institutions Act, 15 U.S.C. § 13c, 52 Stat. 446:

"Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."

STATEMENT OF THE CASE

1. Proceedings in the District Court

Petitioners are twelve national manufacturers of pharmaceutical products. Respondent filed this action for treble damages and for injunctive relief as the assignee of the claims of some sixty commercial pharmacies doing business in metropolitan Portland, Oregon, charging petitioners with violations of the Robinson-Patman Act. The jurisdiction of the district court was invoked under 15 U.S.C. §§ 15 and 26.

The complaint stated five claims, only the second of which is before the Court on this petition.[1] In this claim, respondent alleged that petitioners discriminate in prices charged for drugs between nonprofit hospitals and these commercial pharmacies. As an affirmative defense to the claim, petitioners plead-

[1] Charges of discrimination in sales to city, county and state governments and to the federal government were dismissed for failure to state a claim. Discovery has proceeded on charges of discrimination in sales to proprietary institutions and commercial entities.

ed that drug purchases by the hospitals are exempt from the Robinson-Patman Act by the Nonprofit Institutions Act.

Following discovery on the issues of the nonprofit status and drug dispensing practices of the hospitals, petitioners filed a motion for partial summary judgment under Rule 56 F. R. Civ. Proc. On May 25, 1973 the district court granted the motion, concluding that there was no genuine issue as to any material fact with respect to the nonprofit status of the hospitals or their use of the drugs. The court held that the hospitals' purchases of drugs are exempt from the Robinson-Patman Act under the Nonprofit Institutions Act as a matter of law. See Appendix B, infra, A10.

2. The Decision of the Court of Appeals

Respondent appealed from the judgment to the Court of Appeals for the Ninth Circuit under 28 U.S.C. § 1292(b). On December 26, 1974 the court rendered its opinion vacating the judgment. It affirmed the district court's decision that the hospitals were nonprofit institutions,[2] and it agreed with the district court that the record established the ways in which hospitals dispense drugs. However, it held as a matter of law that a hospital's "own use" of drugs under the Nonprofit Institutions Act extends only to drugs dispensed to bed patients and to patients treat-

[2] In the case of one hospital which is affiliated with a health maintenance organization, the court remanded this issue to the district court for additional discovery. Infra, A5.

ed in the emergency room, and that drugs dispensed by hospitals to patients treated in outpatient clinics, as "take-home" drugs to departing inpatients, and to staff and employees are not purchased for the hospital's "own use."

Petitioners filed a timely petition for rehearing and a suggestion for rehearing in banc. On March 11, 1975 the petition was denied. See Appendix C, infra.

REASONS FOR ALLOWING THE WRIT

The decision of the court of appeals adversely affects the purchase of hospital drug supplies throughout the United States and, in addition, the purchase of all supplies by schools, colleges, universities, public libraries, churches and charitable institutions. The proper construction of the Nonprofit Institutions Act is an important question of federal law that the court of appeals has decided and that has not been, but should be, settled by this Court.

1. The Decision Erroneously Excludes from the Scope of the Nonprofit Institutions Act Purchases of Drug Products Which Are Used in Normal and Essential Services of a Modern Hospital.

The court of appeals held that each of the hospital drug uses to which it denied the protection of the Nonprofit Institutions Act is

> ". . . a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' 'own use.' Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment

> of in-patients or emergency patients. The purpose for which these supplies are purchased — the use to which they are to be put — is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer." Infra, A7.

The court of appeals held, as a matter of law, that purchases of drugs which are dispensed in the following conventional hospital uses are not within the scope of the exemption:

(1) *Drugs dispensed to registered outpatients.* Hospitals maintain outpatient clinics where they provide services for registered hospital patients. Filling prescriptions written by hospital staff doctors for drugs used by these patients as part of their hospital treatment is a routine function of the institution. Outpatient clinics are also an important teaching facility for student doctors and nurses, and are a source of care for the medically indigent.

(2) *Drugs dispensed to departing bed patients as "take-home" prescriptions.* Under orders of the attending physician, hospitals dispense limited amounts of drugs to bed patients who are leaving the hospital, for use during their initial period of convalescence.

(3) *Drugs dispensed to staff physicians and to professional and nonprofessional employees for personal and family use.* Extending pharmacy privileges to hospital staff and employees for their personal and immediate family use is an established and important

benefit of their professional or employment affiliation with the institution.[3]

The appellate court's opinion admits that drug dispensing for these uses is a proper hospital function, but it seeks to limit the exemption to drug dispensing as to which the hospital, and not the patient, "can be said to be the consumer." Infra, A7. In so stating, the court seems to suggest that hospitals have a single function—to provide emergency and bed care for the acutely ill—and that Section 13c can have no broader application, regardless of what these institutions actually do in their community or how they deliver medical services to the public. This erroneous view of the nature of a hospital led the court below into an unrealistic analysis of a practical and important problem.

In fact, modern hospitals have evolved far beyond the limited function recognized by the court. In this process, they have not ceased to be hospitals or to "use" their supplies as hospitals. Modern hospitals are essential community facilities which deliver medical services in many ways and in many places, and their use of drugs cannot be defined in limited terms of care for bedridden patients.

This case concerns specific classes of drug dispensing in which nonprofit hospitals have customarily engaged for many years. These hospital drug uses were excluded by the court of appeals on the single ground that the person who takes the drug does not occupy a hospital bed, and therefore, in the view of the court, becomes the "consumer," whereas, according to the court, the hospital itself is the "consumer" of the pill or other medication administered to a bed patient or an emergency room patient. Its erroneous analysis strikes harshly at a Congressional purpose which the only prior Section 13c decision recognized was to allow such institutions "to operate as inexpensively as possible." *Logan Lanes, Inc.* v. *Brunswick Corp.* (9th Cir. 1967) 378 F.2d 212 at 216, cert. den. (1967) 389 U.S. 898, Anno. 3 A.L.R. Fed. 996 (1970).

[3] The decision of the court of appeals lists three additional classes of hospital drug dispensing which the record shows do not occur in legally significant amounts: Sales to physicians for use in their private practices, refills of "take-home" prescriptions, and occasional sales to "walk-in" customers (members of the public having no connection with the hospital.)

2. The Court's Erroneous Construction of the Nonprofit Institutions Act Prevents Nonprofit Hospitals from Operating as Modern Hospitals Must in Order to Fulfill Their Responsibilities to the Public.

One hundred years ago, the primary function of hospitals was to care for the poor; self-supporting patients were treated at home. Since 1900, major advances in medical science, technology and equipment have expanded the responsibility of hospitals in caring for all classes and members of the community, and with their increasing responsibilities hospitals have become larger and their services more diversified. By 1938, when Section 13c was enacted,[4] the typical

[4] The statutory reference to the institutions' "own use" is general and comprehensive and includes new hospital uses as well as those which were then common. This principle was

general hospital was a complex institution performing a wide variety of functions. This process has continued since the Second World War, under the combined impact of an expanding medical technology, the post-war population boom and rising health care expectations. Modern hospitals are becoming, and in many cases have become, medical centers which have equipment and technologies found only in an institutional setting. These medical centers provide comprehensive diagnostic and treatment services on both an inpatient and outpatient basis.[5]

The accelerating cost of hospital services has created a national crisis. A major response of hospitals to this crisis has been to extend their ambulatory and outpatient services and to provide more comprehensive services, with reduced dependence upon bed care. These are hospital services, and the administration of drugs is an integral part of them. To ignore these facts is

recognized in *Eastern Kentucky Welfare Rights Org.* v. *Simon* (D.C. Cir. Oct. 9, 1974) 506 F.2d 1278 at 1287-1288. See also *Farmington Dowel Products Co.* v. *Forster Mfg. Co.*, (1st Cir. 1969) 421 F.2d 61 at 72-73; *Jerome H. Remick & Co.* v. *American Automobile Accessories Co.* (6th Cir. 1925) 5 F.2d 411, cert. den. (1925), 269 U.S. 556, cited with approval in *Fortnightly Corp.* v. *United Artists* (1968) 392 U.S. 390 at 396, fn. 16; *Cain* v. *Bowlby* (3d Cir. 1940) 114 F.2d 519 at 522-523, cert. den. (1940) 311 U.S. 710, cited with approval in *Browder* v. *United States* (1941) 312 U.S. 335 at 339-340.

[5] The transformation of the traditional general hospital, and the scope of its contemporary community responsibilities are described in "Institutional Pharmacy Practice in the 1970's," (1971), HEW Publication DHEW Pub. No. (HMS) 73-3001. A copy of material parts of that study is attached as Appendix D, infra, A20. See also "The Hospital" by John V. Knowles, President of the Rockefeller Foundation, in Scientific American, September 1973 at p. 128.

to do an injustice to a basic public policy of the Act: The reduction of health care costs.

The court's definition limiting "hospital use" to drugs dispensed to bed patients and to emergency patients is anachronistic, and would limit the Nonprofit Institutions Act exemption to hospital purchases which could not be the subject of Robinson-Patman Act claims in any event.

3. The Court's Decision is An Abrupt and Unfortunate Retreat From the Only Previous Construction of Section 13c, Which Has Been Until Now the Prevailing View of the Statute, and Creates Uncertainty Over Its Scope and Effect Which This Court Should Put to Rest.

This is only the second time that any court of appeals has construed the Nonprofit Institutions Act,[6] and the uncertainty resulting from the evident inconsistency between the two decisions affects every nonprofit institution which seeks and every supplier which extends price concessions in reliance on the statute.

In *Logan Lanes, Inc.* v. *Brunswick Corp.*, supra, (9th Cir. 1967) 378 F.2d 212, cert. den. (1967) 389 U.S. 898, Anno. 3 A.L.R. Fed. 996 (1970), the court applied the exemption to a public university's purchases of bowling alleys and supplies at reduced prices

[6] The Act was referred to in a footnote in an opinion announcing, but dissenting from the decision in *Students Book Company* v. *Washington Law Book Co.* (D.C. Cir. 1955) 232 F.2d 49 at 50-51, fn. 5, cert. den. (1956) 350 U.S. 988. The opinion stated that sales in transactions which were not with the universities, but with self-sustaining campus bookstores for resale at a profit, were not purchases by the universities for their "own use."

for the "primary purpose" of providing physical education programs and recreation for students, faculty and their guests. It held that the exemption was applicable, even though the general public was admitted to the facility, which competed directly with plaintiff's privately operated bowling alley. The court held that the exemption would apply even if public use was "substantial," and it did not require any segregation of use or limitation of access or service to the public.

The court in *Logan Lanes* did not seek to define the traditional services of a university — which might or might not include bowling alleys — nor did it challenge the application of Section 13c to all parts of the institution's program as defined by its administration.

The opinion in *Logan Lanes*, which suppliers, including petitioners, have followed in their marketing policies, is a critically important alternative to the decision in this case and cannot be avoided by asserted distinctions between fixed assets and supplies: Use by persons not affiliated with the institution can be controlled in both cases. As in *Logan Lanes*, the application of the exemption should depend on the predominant purpose of the purchase and its use in fulfilling the needs of the purchasing institution.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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April 10, 1975

APPENDIX A

Opinion of the Court of Appeals

Filed December 26, 1974

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors and all others similarly situated in the State of Oregon,
Plaintiff-Appellant,
vs.
ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation, and WARNER - LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,
Defendants-Appellees.

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U. S. Court
of Appeals

OPINION

No. 73-2342

On Appeal from the United States District Court
for the District of Oregon

Before: MERRILL and WALLACE, Circuit Judges,
and POWELL, District Judge*

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* Honorable Charles L. Powell, Senior United States District Judge for the Eastern District of Washington, sitting by designation.

MERRILL, Circuit Judge:

Plaintiff-appellant commenced this action as the assignee of the antitrust claims of more than sixty retail pharmacies engaged in business in the Greater Portland, Oregon, area. Suit was brought against twelve manufacturers of prescription drugs and sought injunctive relief and damages. Appellant's complaint was stated in five claims, only the second of which is involved in this appeal.[1] That claim charges that defendant drug manufacturers have violated the Robinson-Patman Act, 15 U.S.C. §§ 13, et seq. (1970),[2] by selling to certain hospitals[3] at prices lower than those charged to the retail pharmacies, appellant's assignors; that the favored hospitals, to some extent at least, then engaged in the resale of the drugs so sold. Defendants-appellees contend that the sales

[1] The district court granted a summary judgment on this claim and noted a controlling question; we accepted the interlocutory appeal under 28 U.S.C. § 1292(b).

[2] Section 13(a) makes it "unlawful for any person engaged in commerce * * * to discriminate in price between different purchasers of commodities of like grade and quality * * * where such commodities are sold for use, consumption, or resale * * * and where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them * * *."

[3] Appellant designates the following hospitals: Dwyer Memorial Hospital & Medical Center; Emanuel Hospital; Good Samaritan Hospital & Medical Center; Gresham Community Hospital; Holladay Park Hospital; Physicians and Surgeons Hospital; Portland Adventist Hospital; Portland Osteopathic Hospital; Providence Hospital; St. Vincent Hospital & Medical Center; Tuality Community Hospital; Willamette Falls Community Hospital; Willamette Methodist Convalescent Center; Bess Kaiser Hospital.

in question are exempt from operation of the Act under 15 U.S.C. § 13c (1970), which reads:

> "Nothing in section 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."

After limited discovery and submission of affidavits the district court granted summary judgment in favor of appellees on that claim. The court ruled that each of the fourteen hospitals here involved was "not operated for profit" and that the drugs had been purchased and used for each hospital's "own use." Both of these rulings are assigned as error on this appeal.

We reject appellant's contention that the hospitals did not qualify for exemption (even as to that portion of the purchases which might be "for their own use"), since none of them were "hospitals [or] charitable institutions not operated for profit." It was undisputed that the hospitals derived substantial profits from the sale of drugs and from time to time enjoyed over-all operating surpluses. However, the existence of such profits or surpluses is not in itself enough to foreclose availability of the exemption. In an integrated medical center it is to be expected that one department may provide financial support to another. No enterprise such as these could long remain in existence if each department consistently operated at a loss. Nor could it expect long to continue the fortuity of operating each department or the hospital as a whole pre-

cisely at the break-even point. There was no allegation that these hospitals (with the possible exception of Kaiser, *see infra)*, distributed assets to any interested person, and they could not do so under the terms of their charters. The surpluses were expended in the overall cost of continuing operations or invested for the improvement of facilities.[4] Accordingly, the district court did not err in ruling that the thirteen hospitals other than Kaiser were "not operated for profit" within the exemption. *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212, 216 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967).[5]

We believe the district court erred, however, in granting summary judgment as to sales made to Bess Kaiser Hospital. The effect of this hospital's operation as an element of an organization providing comprehensive health services to members for a predetermined fee, and the possibility that some of its physicians, partners in the Permanente Clinic, receive distributions based on net revenues of the Kaiser Foundation Health Plan (to which revenues from drug

[4] Since the exemption of appellees' sales is founded on the purchasers' status as nonprofit hospitals, we need not consider the possible relevance of the parallel exemption for "charitable institutions not operated for profit."

[5] Since we limit the exemption to purchases by the hospitals "for their own use," we need not decide whether other uses to which the drugs purchased were put could be regarded as removing drugs purchased for such other uses from the nonprofit exemption. Assuming *arguendo* that some purchases by the hospitals were put to uses outside the nonprofit exemption, the exemption as to drugs purchased for hospital uses would not necessarily be unavailable. *Cf. Young Men's Christian Ass'n* v. *Department of Revenue*, — Or. —, 522 P.2d 464 (1974).

sales may contribute), appear to present disputed issues of fact which may be material to the hospital's nonprofit status under the exemption. Moreover, in our judgment the proper legal standard for determining whether Bess Kaiser Hospital is "not operated for profit" in these circumstances cannot be developed on the limited record before us. Since we remand the cause for further proceedings, this issue can more fully be explored below.

The remaining issue is whether purchase of drugs for resale were purchases by the hospitals "for their own use" as that phrase is used in § 13c. With disputed issues of fact resolved in favor of appellant for purposes of the motion for summary judgment, it appears that drugs were distributed by the hospitals under the following circumstances:

1. They were dispensed to the hospitals' inpatients in the course of treatment.

2. They were dispensed in the course of treatment to patients at emergency clinics operated by the hospitals.

3. They were provided to departing in-patients as take-home prescriptions.

4. They were provided to persons who had been inpatients as renewals of prescriptions which had first been filled while those persons were in-patients.

5. They were sold for home treatment to outpatients either at hospital pharmacies or at out-patient clinics.

6. They were sold to the hospitals' employees and students for the private use of purchasers.

7. They were sold to hospitals' physicians for their personal or family use or for dispensation in the course of their private practice.

8. They were sold to walk-in customers who were not hospital patients.

The circumstances covered by categories 1 and 2, relating to in-patient and emergency treatment, cover by far the greater part of hospital distribution. There is no dispute that such dispensing of drugs in the course of treatment in the hospital is the hospitals' own use. It is as to distribution under other circumstances that the parties are in dispute, both factually, as to the frequency of occurrence, and legally, as to whether those uses of the drugs can properly be regarded as the hospitals' own use.

Appellees justify the uses thus made by the hospitals as proper hospital functions. It is asserted that the need of the departing in-patient for take-home drugs is obvious, and that supplying this need is an essential hospital function; that sales to former patients are in connection with hospital or clinic treatment earlier provided and permit such treatment to continue at home; that sale to employees is pursuant to collective bargaining agreements; that sales to students are an aspect of the hospitals' educational programs; that sales to physicians associated with the hospitals are a perquisite of that association; that sale to walk-in customers is limited to instances when

needed drugs cannot be obtained elsewhere; that in all respects a decent regard for the needs of the community and the position of the hospital as a center for the provision of a full range of health services justifies all use made by the hospitals of the drugs sold to them.

We may concede that in these respects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' "own use." Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of in-patients or emergency patients. The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer.

The hospitals here are (quite properly) accommodating patients, staff and strangers with means whereby they can conveniently purchase for *their* use. The question is not whether the hospitals can continue to provide this useful community service. The question is whether in providing it they may acquire the drugs for such resale at an acquisition price that discriminates against local retail druggists. We hold that they may not.

Logan Lanes, Inc. v. *Brunswick Corp.*, *supra*, does not require the contrary result. There the alleged dis-

criminatory pricing was for bowling alley equipment sold to a state university. The lanes had been acquired for use in connection with the university's physical education program and for recreational use of faculty, staff and students and were operated for those purposes. They were not, however, closed to the general public and some public use (the extent was disputed) was made of them. We held:

> "The primary purpose of the purchases established beyond dispute, was to fulfill the needs of the University in providing bowling facilities for its students, faculty and staff. This being the case, any additional use of the bowling facilities by the general public for a fee, even if such use is substantial, would not establish that the purchases were not made for the use of the University."

378 F.2d at 216. The university's public use was indeed in competition with other local alleys, and it may be questioned whether the university should not, in all fairness, have been compelled to choose between the public use and the favorable exemption. But that is not what the statute requires. It requires only that the "supplies" be acquired by the university for its own use. It does not say that once acquired and put to that use they cannot then be used for any other purpose.

Our case does not involve the acquisition of plant equipment. It involves acquisition of stores of supplies. Plant equipment acquired for a university's own use cannot be segregated from that acquired for use

by others, since the same equipment serves both uses. In the case of stores of supplies acquired for consumption the situation is otherwise. Supplies that are resold can readily be segregated from those devoted to a hospital's own use.

In this respect our case is similar to *Students Book Co.* v. *Washington Law Book Co.*, 232 F.2d 49, 50-51 n. 5 (D.C. Cir. 1955), *cert. denied*, 350 U.S. 988 (1956), where the 13c issue was disposed of in a footnote. The plaintiff, a retail seller of law books, complained of the defendant's sales at lower prices of books to campus bookstores at law schools. The distinction drawn by the court was similar to the one we draw here—between sales of books to universities for their own use, *i.e.*, for their libraries, and sales to university connected bookstores for resale to students.

Our holding makes it unnecessary for us to deal with the remaining assignment of error.

The judgment is vacated and the cause remanded for further proceedings.

APPENDIX B

Oral Opinion of the District Court Granting Partial Summary Judgment on May 25, 1973

Despite the suggestion by Mr. Kane that I should make written detailed findings, I do not do so. I cannot; if I took the time to give a written opinion, it would be far beyond the two-month period which Mr. Tilbury mentioned in his letter and my decision would be the same at the end of that time. The grammar would be better, but I intend to rule upon this from the bench at this time.

What is presented, of course, is a question of statutory construction, and I am frequently reminded when I get into statutory construction cases of the statement which Justice Frankfurter made in *Greenwood versus the United States*. In case anybody's interested in the citation, 350 U.S. at 374, who said, I guess with tongue in cheek, "This is a case for applying the canon of construction of the wag who said when the legislative history is doubtful, go to the statute."

I think that's what I'm required to do here, although also ran across a rather intriguing remark made by Justice Holman in the products liability decision that just came out *Markel (phonetic) versus Mul How* (phonetic), 196 Oregon Advance Sheet 1739. He said, "In the final analysis, it is the intention of the legislature that governs the lack of legislative history on this particular point indicates that in all probability the legislature never considered the matter which is true of most statutory construction problems or else they would not exist." And I'm called upon to construe the statute here. However, before I indicate to you what my ruling will be, I'm going to respond to the motion to strike portions of the affidavits which have been submitted by plaintiff, and as I read the cases which Mr. Wright's memo, I believe it was Mr. Wright's memo, talks about, he contends that the moving party in a summary judgment motion not only has the right but indeed the duty to move to strike affidavits which it believes are inappropriate in whole or in part, and then there are in effect the equivalent, because by the plaintiff's objection to the so-called statements by witnesses, deposition witnesses, I suppose is sort of the equivalent of that, but again if I were to rule with the detail that Mr. Kane requested on this motion, not only would it take more than two months, it would probably take about two years.

I'd like to just quote from certain affidavits which have been submitted in this case. First from Mr. Tilbury's affidavit filed March 21, 1973 in Paragraph 14 of the affidavit there is a quotation from what Mr. Tilbury swears is the March 21, 1973 Wall Street Journal in which reference is made to a certain SEC proceeding in which apparently Kaiser agreed to the Federal Court injunction which arose from a case in which the SEC brought charges of securities fraud against Kaiser. Kaiser apparently entered into what I understand would be the equivalent of a consent decree, but the article goes on to say, "Kaiser agreed to a Federal Court injunction without admitting its

guilt, without admitting or denying guilt, but the matter still isn't closed. The Royal Canadian Mounted Police are continuing a criminal investigation in a possible violation of British Columbia Securities law."

In Mr. Kane's March 20 affidavit, which is 45 pages and contains a number of attachments by way of exhibits, Exhibit B5 is — well, excuse me, Exhibits B2 through B6, B1 through B6, is a photocopy of the cover of Rampart's Magazine for November, 1970 together with the pages of an article about Kaiser. The article apparently is entitled "Kaiser and the Health Business."

This is a four-page article, and the justification for the affixing of this article to the affidavit appears on Page 43 of the affidavit. The statement is made, "Additional authoritative indicia that the quality or lack of quality in Kaiser medical and drug care is a disputed issue, is Exhibit B to this affidavit. Exhibit before it made a part of the trial court file by this reference is a copy of the covering article by Judith Milgrom Carnoy titled, "Kaiser: You Pay Your Money and Take Your Chances," published in Rampart's Magazine November, 1970.

It is sufficient for me to say that to whatever extent that material in the affidavits which have been submitted is relevant, I have taken it into account. To the extent that it is irrelevant, I have not taken it into account, and if that is [not] an adequate finding, I'm sure that there will be appellate advice to that effect forthcoming.

With respect to the defendants — excuse me — with respect to the plaintiff's objection to the so-called estimates, that objection will be treated as overruled.

We come, then, to the central issue in this case which is whether or not the defendants' motion for summary judgment should be granted, and I have no hesitation in saying that I believe that it should and I intend to grant it for the reasons I will indicate briefly.

The vast majority of the drugs which are purchased here and which are used by the hospitals are for the use of the hospital clearly within the meaning of Section 13(c); whether that percentage be 85 or 90 or 95 is of no moment because even Mr. Kane agrees that the truly in-patient that is the hospitalized bed patient and for practical purposes, the person who receives treatment in the emergency ward, receives the type of treatment for which the section was intended.

This leaves us with the other categories which have been mentioned, and I will simply summarize them. With respect to out-patient treatment whether it be initial or repeated out-patient treatment, I do not believe that it was the Congressional purpose to render inapplicable the statute merely because there was a change in the distribution of health care wherein the degree of out-patient treatment increased over the years since the '30's when this statute was passed.

With respect to the take-home drugs, that is by those who are issued prescriptions by doctors at the

time that they are discharged from the hospital where they have normally been in-patient or bed patient, it seems clear to me that that also falls within the clear meaning of the applicability of the statute and that such drugs are indeed for the use of the hospital and thus qualify for the exemption.

With respect to the furnishing of drugs to employees and staff physicians and other members of the staff, I have some mild degree of question, but not sufficient in my mind, to justify denying the motion for summary judgment. I think this may fairly be said to be for the use of the hospital.

With respect to the walk-in patients, I am persuaded by *Logan-Lanes* that even though it might be said that those are not for the use of the hospital, nonetheless, the fact that walk-in sales exist in the amounts indicated by this record would not justify withdrawing from the hospitals the exemption of 13(c).

Furthermore, the fact that there is a dispute apparently as to the exact number of walk-in sales or the exact dollar amount of walk-in sales, would not in my judgment amount to a genuine issue of material facts sufficient to justify denial of the motion for summary judgment.

In short, I believe under *Logan Lanes*, the conduct and the pattern established here by this record is such that the Ninth Circuit would, in fact, conclude that a motion for summary judgment should be granted as to the second cause of action because I believe that the Ninth Circuit would agree with me that there is no genuine issue of material fact in the second cause of action.

Furthermore, even though I have a little more difficulty in my mind with the Kaiser situation than with the so-called fee for service or so-called non-profit hospitals, that is Emanuel, St. Vincent and the others which have been mentioned, nonetheless, I conclude that it is fairly within the Congressional purpose in that the establishment of satellite pharmacies and satellite clinics throughout the area is not so divorced either conceptually or substantially from the purposes and functions of a hospital, the central hospital institution itself.

I conclude it's not so divorced as to justify withholding from that organization benefits of Section 13(c).

As I say, I have some — I am not as sure in my own mind with respect to the Kaiser situation as I am with respect to the other hospitals which have been mentioned, but if, in fact, there is a policy judgment to be made analyzing and studying the policy that Congress had in mind and how it can best be effectuated at this point in time, 35 years after it's enacted, the Ninth Circuit is a far better able Court and group and body to elaborate policy and if, in fact, the Kaiser type of plan which as Mr. Clarke has said and as indeed Mr. Kane has agreed is the emerging form, whether or not that takes such a form as to have significant effects on persons such as plaintiff assignors

and if, in fact, the action of this Court is destructive of what Congress' policy is or ought to be, then I think that is a policy decision for the Ninth Circuit to make.

I do not believe I am doing a disservice to the Congressional policy by rendering this decision in this fashion.

Learned Hand — at one time, I think it was Learned Hand, spoke of the art of statutory construction as being the proliferation of purpose and necessarily, when a single District Judge in Portland, Oregon sits and tries to proliferate the Congressional purpose of three-and-a-half decades ago, one must approach the task with some degree of diffidence and hesitation. I've given it the best study I can, Gentlemen, and I believe that this decision is consonant with and not in contradiction to the Congressional purpose of enacting 13(c) and so for the reasons I have indicated and bearing in mind that I'm sure my learned brethren on the Ninth Circuit will forgive the atrocity of my grammar, I grant the motion.

Furthermore, on the assumption that Mr. Kane would move as he did in connection with the earlier ruling of this Court, I am prepared to discuss Section 1292 Sub-B. Do you so move, Mr. Kane?

(Whereupon a brief off-the-record discussion was had.)

MR. KANE: All right, Your Honor, we would be happy to have the Court certify this for an interlocutory appeal, although we are not very happy with the state of the record.

THE COURT: And do you renew the motion which you made last fall at the time I ruled on Causes of Action No. 3 and 4 for a similar certification?

MR. KANE: Yes, we do, Your Honor.

THE COURT: All right. Do you gentlemen desire to be heard in opposition to that motion—Mr. Clarke?

MR. CLARKE: No desire to be heard, Your Honor.

THE COURT: I'm satisfied that this order as well as the corresponding orders issued last fall concerning Count III and Count IV involve together a controlling question of law as to which there is a substantial ground for difference of opinion and I am furthermore of the opinion strongly that an immediate appeal from this order and the one last fall disposing of Counts III and IV may materially advance the ultimate termination of litigation.

I will so state in writing pursuant to the provisions of 28 U.S.C., 1292, Subsection B, when you present such an order and I would assume, Mr. Clarke, that you will follow the issue of policy that we established some time ago.

You should prepare an order, check it with Mr. Kane and be prepared to present it to me in such fashion that you can assure the Court that there is no objection as to form.

FILED
March 11, 1975
Clerk
U.S. Court of Appeals
DOCKETED
March 12, 1975

APPENDIX C

Order of the Court of Appeals Filed March 11, 1975
Denying Petitioner's Petition for Rehearing

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,	)	No. 73-2342
Plaintiff-Appellant,	)	ORDER
vs.	)	
ABBOTT LABORATORIES, et al.,	)	
Defendants-Appellees.	)	

Before: MERRILL AND WALLACE, Circuit Judges,
AND POWELL, District Judge

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for a rehearing in banc.

The full court has been advised of the suggestion for an in banc hearing, and no judge of the court has requested a vote on the suggestion for rehearing in banc. Fed. R. App. P. 35(b).

The petition for rehearing is denied and the suggestion for rehearing in banc is rejected.

The applications of American Hospital Association and Oregon Association of Hospitals to appear as amici curiae are denied.

APPENDIX D

A partial text of "Institutional Pharmacy Practice in the 1970's," 28 American Journal of Hospital Pharmacy 240 (1971) HEW Publication DHEW Pub. No. (HMS) 73-3001. The authors are Donald C. Brodie, of the University of California, and Mrs. Joe B. Graber, who were, respectively, the Director and the Special Assistant to the Director of the drug-related studies program of HEW.

Early in the 1960's the American Hospital Association approved a ". . . Statement on the Changing Hospital. . . ." The underlying concept in the Statement was that the hospital would become the repository for and custodian of a community's health resources — physical plant, technical manpower and equipment. Steps were taken in the past decade toward fulfilling this projection, in fact, some believe the hospital now is acquiring the qualities of the community health center.

Numerous factors are contributing to this development. For example, the hospital is growing "centrally" because of increasing demands for its services, continual scientific specialization, and centralization of health resources. On the other hand, it is growing "peripherally" since it is being required to extend its services into the community because of the forces created by the physician shortage in selected areas and the need for lessening the high density of patients at the hospital. Thus, the community hospital

is growing "inwardly" and "outwardly" simultaneously.

As health centers, some community hospitals are providing a full spectrum of diagnostic and treatment
H Dezendorf 7578 D3-7
services to the sick in addition to preventive and maintenance services to the apparent well. Community hospitals are assuming responsibility for selected social, environmental, rehabilitative and other health-related services. Some of this centralization of services has resulted from shifts taking place in the delivery of selected services from long-term to acute care hospitals. The sharing of services also has been a contributing factor.

The emergence of the hospital as a community health center frequently represents a realignment of resources and management. Horizontal realignment is taking place through the establishment of satellite hospital systems, chains and mergers, while vertical realignment is seen where hospitals are providing for graded levels of care.

The facilities for a system of comprehensive care may be clustered on a common campus, structured around the hospital. In other cases, services will be provided in an off-campus facility located at some other point in the community to facilitate access to primary care of some specialized service. Modern communication systems will permit continuous contact with the parent institution. Whatever arrangements develop in a given community, the hospital retains the

central focus while its authority and that of its medical staff will extend to wherever in the community its services are needed.

Supreme Court, U. S.
FILED
OCT 1 1975
MICHAEL RODAK, JR., CLERK

APPENDIX

In the Supreme Court
of the United States

OCTOBER TERM, 1975

No. 74-1274

ABBOTT LABORATORIES, et al.,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., etc.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR CERTIORARI FILED APRIL 10, 1975
CERTIORARI GRANTED JUNE 23, 1975

STEVENS-NESS LAW PUB. CO., PORTLAND, ORE. 9-75

In the Supreme Court
of the United States

OCTOBER TERM, 1975

No. 74-1274

ABBOTT LABORATORIES, et al.,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., etc.,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

Civ. No. 71-543

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors and all others similarly situated in the State of Oregon,

Plaintiff,

v.

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Defendants.

RELEVANT DOCKET ENTRIES

August 6, 1971	Filed class action complaint for damages and injunctive relief under the antitrust laws; jury trial requested.

August 6, 1971	Filed plaintiff's interrogatories to defendants (first set).
August 9, 1971	Issued summons to marshal.
October 28, 1971	Filed return of service of summons on all defendants.
November 22, 1971	Filed amended complaint for damages and injunctive relief under the antitrust laws; jury trial requested.
November 23, 1971	Filed plaintiff's amended interrogatories to defendants (first set).
December 22, 1971	Filed request for admissions.
December 22, 1971	Filed defendants' motions (1) to dismiss third and fourth causes of action; (2) to limit discovery and for summary judgment as to the second cause of action; (3) to limit discovery and for summary judgment as to the fifth cause of action.
January 10, 1972	Filed notice of deposition of Warren Kobelin.
January 12, 1972	Filed motion to defer deposition of Warren Kobelin with memorandum in support of motion attached.
January 28, 1972	Filed plaintiff's certificate and statement.
February 18, 1972	Filed plaintiff's supplement to certificate and statement.

September 11, 1972	Filed plaintiff's brief in support of plaintiff's certificates and statements.
September 13, 1972	Filed plaintiff's designation of hospital pharmacies.
October 3, 1972	Filed affidavit of Stanley Hartman re Emanuel Hospital drug distribution.
October 4, 1972	Filed answer of defendant Endo Laboratories, Inc. to amended complaint.
October 4, 1972	Filed answer of defendant American Home Products Corporation to amended complaint.
October 4, 1972	Filed answer of defendant E. R. Squibb & Sons, Inc. to amended complaint.
October 4, 1972	Filed answer of defendant Squibb Corporation to amended complaint.
October 4, 1972	Filed answer of defendant Eli Lilly and Company to amended complaint.
October 5, 1972	Filed answer of defendant Bristol-Myers Company to amended complaint.
October 5, 1972	Filed answer of defendant A. H. Robins Co., Inc. to plaintiff's amended complaint.
October 5, 1972	Filed answer of defendant Abbott Laboratories.

October 5, 1972	Filed answer of defendant William H. Rorer, Inc. to amended complaint.
October 5, 1972	Filed answer of Carter-Wallace, Inc. to amended complaint.
October 5, 1972	Filed answer of Warner-Lambert Company to amended complaint.
October 5, 1972	Filed answer of Ortho Pharmaceutical Co. to amended complaint.
October 5, 1972	Record of hearing on question of further discovery re second cause of action.
October 6, 1972	Filed plaintiff's motion to prohibit destruction of documents and brief in support.
October 26, 1972	Filed plaintiff's motion for leave to file and serve Rule 34 request for documents and brief and affidavit in support of motion.
October 30, 1972	Filed order that plaintiff's motion to prohibit destruction of documents by defendants is denied.
November 13, 1972	Filed plaintiff's notice of filing of sealed exhibits.
November 16, 1972	Filed plaintiff's exhibits—certified copies of judgment granting preemptory writ of mandamus and findings of fact and conclusions of law, *A. H. Robins Company, Inc.* v. *Human Relations Agency of the State of California.*

November 27, 1972	Filed consent order that plaintiff's assignors and defendants shall exercise good faith and their best efforts to preserve certain described documents.
November 27, 1972	Filed affidavit of Henry Kane re Kaiser Hospital, an alleged "non-profit hospital."
November 27, 1972	Hearing on motion for leave to file and serve Rule 34 request for documents; order denying motion.
December 4, 1972	Filed plaintiff's second supplemental certificate and statement.
December 29, 1972	Filed plaintiff's motion for discovery and brief in support of motion.
January 2, 1973	Filed affidavit of Logan Wallace re refilling of private doctor's office prescription by Emanuel Hospital pharmacy.
February 5, 1973	Filed affidavit of Raymond L. Montee re hospital drug purchases.
February 5, 1973	Filed plaintiff's motion re limited discovery and brief in support of motion.

February 8, 1973	Filed plaintiff's motion for second cause of action discovery and brief in support of motion.
February 8, 1973	Filed affidavit of Logan Wallace re refilling of private doctor's office prescription by Portland Adventist Hospital.
February 15, 1973	Filed plaintiff's motion for order requiring answers to interrogatories or in the alternative for an order striking defendants' pleadings and for default, and memorandum.
February 26, 1973	Filed Eileen Cummins affidavit re Retail Clerks Union, Local 1092, prescription drug purchases from Kaiser Hospital and related clinic pharmacies and Willamette Community Hospital.
February 27, 1973	Filed plaintiff's excerpts from defendant A. H. Robins Company, Inc. testimony re drug price and practice discrimination against community pharmacies.
February 27, 1973	Filed motion and brief in support of motion re taking depositions of officers, employees, etc. of defendants concerning drug distribution practices.
March 12, 1973	Filed plaintiff's notice under protest re second cause of action "discovery."

March 12, 1973	Filed defendants' motion for summary judgment on second cause of action.
March 12, 1973	Filed defendants' memorandum of points and authorities in support of motion for summary judgment on plaintiff's second cause of action.
March 13, 1973	Filed Rule 56 affidavit of Henry Kane disputing accuracy of charts defendants submitted to court.
March 13, 1973	Filed exhibit to defendants' memorandum of points and authorities in support of motion for summary judgment on plaintiff's second cause of action.
March 20, 1973	Filed plaintiff's Rule 56 affidavit in opposition to defendants' motion for summary judgment on the second cause of action.
March 20, 1973	Filed plaintiff's memorandum re plaintiff's Rule 56 affidavit in opposition to defendants' motion for summary judgment on the second cause of action.
March 21, 1973	Filed Rule 56 affidavit of Roger Tilbury in opposition to defendants' motion for summary judgment on the second cause of action.

March 21, 1973	Filed exhibit to defendants' motion for summary judgment on second cause of action.
March 22, 1973	Filed defendant A. H. Robins Company, Inc. documents pertaining to second cause of action.
March 22, 1973	Filed plaintiff's Rule 56 affidavit disputing accuracy of exhibit to defendants' motion for summary judgment on the second cause of action.
March 22, 1973	Filed Rule 56 affidavit of Logan Wallace, president of plaintiff, in opposition to defendants' motion for partial summary judgment on the second cause of action.
March 28, 1973	Filed Rule 56 affidavit of Howard Steinbach in opposition to defendants' motion for summary judgment on the second cause of action.
April 3, 1973	Filed plaintiff's Rule 56 affidavit re audit documents of alleged "nonprofit" hospitals.
April 6, 1973	Filed plaintiff's objection to use or destination testimony re defendants' motion for summary judgment on second cause of action and brief in support of objection.

April 6, 1973	Filed defendants' motion to strike plaintiff's Rule 56 affidavits in opposition to defendants' motion for summary judgment on the second cause of action.
April 10, 1973	Filed Rule 56 affidavit of Stanley E. Hartman in opposition to defendants' motion for summary judgment on the second cause of action.
April 10, 1973	Filed plaintiff's brief in opposition to defendants' motion to strike plaintiff's Rule 56 affidavit in opposition to defendants' motion for summary judgment on the second cause of action.
April 10, 1973	Filed Rule 56 affidavit of Henry Kane re "personal knowledge" of matters in prior Rule 56 affidavits.
April 10, 1973	Filed second Rule 56 affidavit of Logan Wallace, president of plaintiff, in opposition to defendants' motion for summary judgment on the second cause of action.
April 10, 1973	Filed second Rule 56 affidavit of Howard Steinbach in opposition to defendants' motion for summary judgment on the second cause of action.

April 16, 1973	Filed plaintiff's brief in opposition to defendants' motion for summary judgment on the second cause of action.
April 16, 1973	Filed plaintiff's Rule 56 affidavit of Raymond L. Montee re "charitable" nature of Bess Kaiser Hospital, Portland, Oregon.
April 18, 1973	Filed transcript of proceedings, dated January 8, 1973.
April 23, 1973	Filed second Rule 56 affidavit of Stanley Hartman in opposition to defendants' motion for summary judgment on the second cause of action, re preferential drug prices of listed defendants.
April 24, 1973	Filed affidavit of Henry Kane re Bess Kaiser Hospital, an alleged "nonprofit" hospital.
April 25, 1973	Filed Rule 56 affidavit of Henry Kane in opposition to defendants' motion for summary judgment on second cause of action, re drug sales to public and others by 14 alleged "nonprofit" hospitals.
May 18, 1973	Filed third Rule 56 affidavit of Stanley Hartman in opposition to defendants' motion for summary judgment on the second cause of action, re evidence of drug sales to non-hospitalized

	purchasers, and notice of deposit of prescription drug containers exhibit with clerk of the court.
May 18, 1973	Filed prescription drug containers exhibit identified in above affidavit.
May 18, 1973	Filed defendants' reply memorandum in support of motion for summary judgment.
May 22, 1973	Filed third Rule 56 affidavit of Howard Steinbach in opposition to defendants' motion for summary judgment on the second cause of action.
May 23, 1973	Filed plaintiff's objection to hospital witness "estimates" of "walk-in" drug sales to members of public, and brief in support of objection.
May 23, 1973	Filed fourth Rule 56 affidavit of Stanley Hartman in opposition to defendants' motion for summary judgment on plaintiff's second cause of action, re drug price overcharges by Bess Kaiser Hospital, and alleged "nonprofit" hospital.
May 24, 1973	Filed plaintiff's second brief in opposition to defendants' motion for summary judgment on the second cause of action.
May 25, 1973	Hearing on defendants' motion for summary judgment; order

admitting all physical exhibits tendered with affidavits; order granting defendants' motion for summary judgment on second cause of action; plaintiff's objections to summary judgment denied; defendants' motion to strike certain affidavits—order granting and denying in part. Order denying plaintiff's motions for additional discovery previously filed.

June 5, 1973 — Filed plaintiff's motion for reconsideration, brief in support of motion, and Rule 56 affidavit of Stanley Hartman in support of motion.

June 8, 1973 — Filed defendants' response to plaintiff's motion for discovery.

June 11, 1973 — Filed plaintiff's reply brief in support of motion for order permitting commencement of discovery.

June 22, 1973 — Filed order and partial summary judgment: (1) third and fourth causes of action of amended complaint are dismissed for failure to state claims upon which relief can be granted; (2) summary judgment is hereby entered in favor of defendants on the second cause of action of amended complaint; (3) court is of opinion that this

order involves controlling questions of law as to which there is substantial ground for difference of opinion and that an immediate appeal from this order may materially advance the ultimate termination of the litigation.

June 22, 1973 — Filed order re stipulation as to certain evidence, affidavits, etc. accepted for purposes of consideration of defendants' motion for summary judgment.

June 27, 1973 — Filed transcript of proceedings dated October 24, 1972.

June 27, 1973 — Filed transcript of proceedings dated October 5, 1972.

June 27, 1973 — Filed transcript of proceedings dated September 11, 1972; October 5, 1972; October 11, 1972; October 24, 1972; November 27, 1972; and February 5, 1973.

July 2, 1973 — Plaintiff's application for permission to appeal pursuant to 28 U.S.C. § 1292(b) received by Court of Appeals.

July 23, 1973 — Order entered granting plaintiff permisison to take interlocutory appeal from the order of district court granting summary judgment on second cause of action.

July 31, 1973	Filed affidavit of Henry Kane re William H. Rorer, Inc. "In-Hospital Use Only" drug container and notice of deposit of said exhibit with court clerk.
August 3, 1973	Plaintiff's designation of record filed.
August 9, 1973	Defendants' cross-designation of record filed.
September 10, 1973	Plaintiff's supplemental designation of record filed.
October 2, 1973	Excerpt of October 5, 1972 proceedings filed.
October 4, 1973	Excerpt of May 25, 1972 proceedings filed.
October 4, 1973	Filed transcript of proceedings dated May 25, 1973.
October 9, 1973	Record on appeal filed.
December 26, 1974	Opinion and judgment of the Court of Appeals for the Ninth Circuit.
March 11, 1975	Order entered denying petition for rehearing.
June 23, 1975	Order entered granting writ of certiorari.

[R. 49]

United States District Court for the District of Oregon

SUPPLEMENTAL ORDER

(Filed September 29, 1971; caption omitted in printing)

This order supplements the order dated September 24, 1971. After reviewing the transcript of the proceedings, I find that the September 24th order does not include two items.

IT IS ORDERED:

1. Until the court has determined that this case may proceed as a class action, answers to plaintiff's first set of interrogatories are deferred except those interrogatories which are directed to the class action issue.

2. The defendants will not be required to file an answer to the complaint until November 15, 1971.

Dated this 29th day of September, 1971.

(Subscription omitted in printing)

[R. 52]

United States District Court for the District of Oregon

AMENDED COMPLAINT FOR DAMAGES AND INJUNCTIVE RELIEF UNDER THE ANTITRUST LAWS; JURY TRIAL REQUESTED

(Filed November 21, 1971; caption omitted in printing)

FIRST CAUSE OF ACTION

Plaintiff files this amended complaint on behalf of its assignors and, requesting trial by jury, alleges as follows:

JURISDICTION AND VENUE

1. Jurisdiction and venue are founded upon the Clayton Act (38 Stat. 730, Oct. 15, 1914, Ch. 323, Title 15 U.S.C. § 13 et seq.) as amended by the Robinson-Patman Act (June 19, 1936, Ch. 592, 49 Stat. 1526) and other amendments, and upon the Sherman Act (July 2, 1890,

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Ch 647, 26 Stat. 209), 15 U.S. C. § 1 et seq., and subsequent amendments, and on 15 U.S.C. §§ 1, 2, 8, 9, 13, 15, 22 and 26, and related sections.

2. Venue is founded on 15 U.S.C. §§ 15 and 22, and 28 U.S.C. § 1391. Plaintiff and its assignors are residents of the State of Oregon. Defendants, and each

of them, are now and at all times herein mentioned have been transacting business and are found within this District.

3. "Plaintiff's assignors" are present and former owners of community pharmacies who have assigned to the plaintiff, for a valuable consideration, their causes of action under the antitrust laws. Plaintiff's assignors are set forth in Exhibit "A" to this complaint.

PLAINTIFF

4. Plaintiff is, and at all times herein mentioned has been, a non-profit corporation incorporated and in good standing under the laws of the State of Oregon, with its offices in Portland, Oregon. Plaintiff is composed of members who own and operate community pharmacies in the State of Oregon. One of its purposes is to secure and preserve equitable trade conditions for the practice of pharmacy and the benefit of its members and the public.

DEFENDANTS

5. Defendant Abbott Laboratories is an Illinois corporation with its principal office in North Chicago, Illinois, and transacts business in Oregon.

It is also a leading prescription drug producer which manufactures primarily hospital and pediatric, diagnostics, laboratory and hospital equipment, animal health, agricultural and chemical products. Some of

its better known products are Erythromycin antibiotic, Compocillin antibiotic, Nembutal, Placidyl sedative, vitamins, anoretics, cardiovascular agents, Similac (an infant formula), Murine eye care, golf balls and Sucaryl. Its sales

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exceeded $450 million in 1970.

6. Defendant American Home Products Corporation, a Delaware corporation with its principal office in New York City, is admitted to do business in Oregon, and transacts business in Oregon. Wyeth Laboratories, a division of American Home Products Corporation, transacts business in Oregon. It is a diversified producer of prescription drugs, goods and household products. Its sales during 1970 exceeded $1 billion. Some of its better known products are Ovral (an oral contraceptive), Equanil (a tranquilizer), Phenergan (anti-histamine), Premarin (estrogen), Omnipen (ampicillin), Atromid-S (anti-cholesterol), Anacin, Preparation H, Dristan, Kolynos (toothpaste), BiSoDol, Infrarub, Dondril (cold tablets), Griffin shoe polishes, Wizard (deodorizers), 3-in-1 Oil, Aero Shave, Aerosol Sani-Flush, Black Flag (insecticide), Easy-Off oven cleaner, Woolite soap, Chef Boy-Ar-Dee (food specialties), Frankly Dry Toasted Nuts, Jiffy Pop Popcorn, Dennison's Hot Chili, Teflon coated pots and pans, and E. J. Brach (candies).

7. Defendant Bristol-Myers Company is a Delaware corporation with its principal office in New York City, and transacts business in Oregon. Bristol Laboratories, a division of Bristol-Myers Company, transacts business in Oregon. It is a leading domestic producer of toiletries and prescription and proprietary drugs, household goods and nutritional formulations. Key products include Bufferin, Excedrin, Vitalis, Ban, Vote, Sal Hepatica, Clairol, Windex, Drano, Endust and Metrecal. Its net sales exceeded $980 million during 1970.

8. Defendant Carter-Wallace, Inc., a Delaware corporation with its principal office in New York City, transacts business in Oregon. It is engaged in making consumer products and prescription drugs. Its net sales exceeded $125 million in 1969. Some of its products are Arrid, Nair, Carter's Pills laxative, Miltown (meprobamate), Rondomycin, Frenchette (salad dressing) and pet food.

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9. Defendant Eli Lilly and Company, an Indiana corporation with its principal office in Indianapolis, Indiana, is admitted to do business in Oregon, maintains an office in Portland, Oregon, and transacts business in Oregon. It is one of the leading producers of pharmaceuticals with about 800 medicinal products for use and approximately 200 other items. Its net sales exceeded $590 million in 1970, and it has a net working capital in excess of $150 million, making it the largest U. S. ethical drug company with about

10% of the industry's volume. Its product line includes agricultural chemicals, analgesics, animal health products, animal nutrients and growth stimulants, antibiotics, anti-depressants, anti-diabetic agents, biologicals, bulk antibiotics, bulk chemicals, empty gelatin capsules, hematinics, hormones, lawn and garden products, sedatives, veterinary products, vitamins and beauty products (the last through its subsidiary, Elizabeth Arden Sales Corporation). Lilly owns 13 plants and facilities in the United States and Puerto Rico, maintains warehouse space in eight cities, and sales offices in 43 cities in the U. S. and Puerto Rico. In addition, its subsidiaries and affiliates own or lease plants and facilities in 23 foreign countries. It also owns a stockyard in Indianapolis and produces injection-molded plastic containers.

10. Defendant Endo Laboratories, Inc., a Delaware corporation with its principal office in Garden City, New York, transacts business in Oregon and is a subsidiary of E. I. DuPont de Nemours and Co., Inc., a Delaware corporation admitted to do business in Oregon, and transacts business in Oregon. DuPont de Nemours & Co. is the world's largest chemical company. It is engaged in manufacturing a vast array of products including those related to textiles, rubber, plastics, chemicals and allied products, transportation, petroleum refining, machinery, electrical, paper, printing, agriculture, metals and metal fabricating, construction,

sporting goods, explosives, film, industrial and biochemicals, pigments and many other products. It employs more than 100,000 persons and had net sales in 1970 exceeding $3 billion. Until recently DuPont was also the largest single stockholder in General Motors Corp.

11. Defendant Ortho Pharmaceutical Corporation, a New Jersey corporation with its principal office in New Brunswick, New Jersey, is a division of Johnson & Johnson, and transacts business in Oregon. Johnson & Johnson is a major producer of health care products. Its products include surgical dressings and consumable hospital products, drugs, textiles, industrial tapes, ligatures and sutures, surgical instruments, toiletries and hygenic products, baby care items, contraceptives, veterinary products, industrial tapes, paper products, sanitary napkins, Micrin mouthwash, disposable diapers, sedatives, muscle relaxants, antifungal drugs, sedatives, birth control pills, vaccines, needles and veterinary products. It maintains 61 manufacturing plants in 33 countries. Its net sales in 1970 exceeded $1 billion.

12. Defendant Squibb Corporation, a Delaware corporation with its principal office in New York City, transacts business in Oregon. Defendant was formed by the 1968 merger of Beech-Nut Life Savers and E. R. Squibb & Sons, Inc. Its operations encompass prescription drugs, food and confectionary items (through Beech-Nut and Dobbs House), cosmetics

(through Lanvin-Charles of the Ritz), surgical instruments (through Edward Weck & Co.), confections, and household products. Its net sales exceeded $700 million in 1970.

13. Defendant E. R. Squibb & Sons, Inc., a Delaware corporation with its principal office in New York City, transacts business in Oregon and is a subsidiary of defendant Squibb Corporation.

14. Defendant A. H. Robins Company, Inc., a Virginia corporation with its principal office in Richmond, Virginia, transacts business in Oregon. It is engaged in the manufacture and/or sale of

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pharmaceutical specialties, pet care products, cough and cold preparations, snack foods, French perfumes, lip balms, hand creams, potato chips, crackers, cookies, packaged nuts, tranquilizers, anti-rheumatics, and also operates pet departments. It net sales in 1970 were in excess of $130 million.

15. Defendant William H. Rorer, Inc., a Pennsylvania corporation with its principal office in Fort Washington, Pa., transacts business in Oregon. Defendant is a subsidiary of Rorer-Amchem, Inc., a Pennsylvania corporation. It deals primarily in pharmaceutical and agricultrual chemicals. Its most important products are Maalox, an antacid, and Aniban, a herbicide used largely in the growth of soy beans. It also makes surgical products, metalworking chem-

icals, plant growth regulators, preparations for skin disorders, sleep inducing drugs, weed killers, coatings for aluminum, copper and steel, and adhesive and sealing compounds. Its sales exceeded $130 million in 1970.

16. Defendant Warner-Lambert Pharmaceutical Company, a Delaware corporation with its principal office in Morris Plains, New Jersey, transacts business in Oregon. Warner-Chilcott Laboratories, a division of Warner-Lambert Pharmaceutical Company, transacts business in Oregon. It acquired (through merger), Parke, Davis & Co., an important drug producer, in 1970, as well as portions of Eversharp. It is an important factor in the production of drugs, chewing gum, opthalmic and optical products, shaving products and medical-scientific instruments. It manufactures Bromo-Seltzer, Anahist, Efferdent, Listerine, Pristeen, Schick, Dentyne, Chiclets, Clorets, Tridents, Certs, Rolaids, Smith Brothers Cough Drops, Richard Hudnut and DuBarry (cosmetics), Lactona (dental products), chemicals and many others. Its net sales in 1970 exceeded $1.2 billion.

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TRADE AND COMMERCE

17. The drug industry is a large and expanding one. The value of shipments by pharmaceutical manufacturers in the United States rose from about $900 million in 1947 to $4.7 billion in 1968, and to approx-

imately $7 billion in 1970. Defendants are among the largest manufacturers of drug products in the United States.

18. Defendants' operations have for some years involved the constant transmittal across state lines and in interstate commerce into Oregon of drugs and of advertisements, inducements, communications and other business transactions. Defendants and plaintiff's assignors obtain much of their product supply from defendant manufacturers within the normal course of business. Such purchases and deliveries directly affect the total volume of drug products shipped into Oregon, and affect, alter and modify the total volume shipped in interstate commerce.

19. Direct drug sales by manufacturers in 1969 in the United States totaled $4 billion. Of that total, $158.8 million, or 3.9 percent, were sold to the federal government and its hospitals. Direct sales to all types of hospitals totaled $764 million, up eight percent from 1968, and were approximately 20 percent of all 1969 drug sales.

20. Plaintiff's assignors are in direct competition with the favored customers of defendants for the patronage of ultimate consumers of defendants' drugs except enrolled patients hospitalized in the purchasing institution.

UNLAWFUL DISCRIMINATION

21. More than four years ago and continuing to

and including the date of the filing of this amended complaint, defendants and each of them unlawfully in the course of interstate commerce, in the sale of drugs of like grade and quality, by granting discounts, allowances, compensation, payments, services, brokerage, terms, facilities, rebates and lower

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prices than said commodities were sold to plaintiff's assignors, and such favorable discounts, allowances, compensation, payments, services, brokerage, terms, facilities, rebates and lower prices were not made available to plaintiff's assignors on equal terms.

22. Defendants' drugs were sold in interstate commerce for use, consumption, resale or distribution within the United States and multiple sales took place in interstate commerce.

23. The unjust and unlawful differentials set forth in paragraph 21 of this amended complaint are not attributable to differences in the cost of manufacture, sales or delivery resulting from the differing methods or quantities in which such commodities are to such purchasers sold or delivered.

24. The exemption given sales to schools, colleges, universities, public libraries, churches, hospitals and charitable institutions not operated for profit by 52 Stat. 446, c. 283, 15 U.S.C. § 13c, where the drugs are employed for their own use, is limited to drugs used exclusively within the confines of the purchasing in-

stitution for enrolled patients of the institutions while such patients are so confined and for no other purpose.

25. Sale or distribution of any drug purchased at a discriminatory discount, allowance, compensation, payment, service, brokerage, term, facility, rebate or lower price by a non-profit institution to any person other than an enrolled patient in the purchasing institution is a violation of Section 2 of the Clayton Act as amended by the Robinson-Patman Act, 15 U.S.C. § 13.

26. The exemption granted by 15 U.S.C. § 13c does not include cities, counties, states and the federal government other than in their capacities as operators of hospitals and charitable institutions not operated for profit when they administer drugs to enrolled patients.

27. Said acts of discrimination by defendants against plaintiff's assignors enable the favored competitors to offer drugs at no cost or nominal cost to their consumers and for sale at prices substantially

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below the retail prices that must be charged by plaintiff's assignors if they are to remain in business. Thus, plaintiff's assignors have been and are rendered less able to compete, and competition in said line of commerce has been, and is, substantially lessened and impaired.

28. The unlawful discrimination of the defendants

set forth herein compels plaintiff's assignors to pay a higher discriminatory unit cost for drugs of the same type.

29. The unlawful discrimination of the defendants set forth herein subsidizes defendants' favored purchasers with unearned and unjustified lower prices at the expense of plaintiff's assignors.

30. The unlawful discrimination of the defendants set forth herein compels plaintiff's assignors to contribute all or a disproportionate share of defendants' profits on drugs.

31. Said acts of discrimination by defendants against plaintiff's assignors constitute subsidized or below-cost sales to the favored purchasers at the expense of the retail customers of plaintiff's assignors, with resultant injury of said assignors and to the general public.

32. Said acts of discrimination by defendants against plaintiff's assignors preclude said assignors from competing successfully and threaten to, and if continued, will, terminate said assignors as competitors in drugs and cause them irreparable damage and reduce the number of competitors and thereby tend to create a monopoly, and to injure, destroy or prevent competition.

33. Said acts of discrimination by defendants against plaintiff's assignors have, to date, resulted in the failure of numerous community pharmacies in the State of Oregon, and unless said acts of discrimina-

tion are permanently enjoined, will result in the failure of an additional and substantial number of community pharmacies in the State of Oregon, including at least some of plaintiff's assignors.

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34. Defendants, directly and indirectly, sell drugs to proprietary nursing homes, hospitals and other institutions at more favorable discounts, allowances, compensation, payments, services, brokerage, terms, facilities, rebates and lower prices than are made available to plaintiff's assignors.

35. Said proprietary nursing homes, hospitals and other investor-owned institutions resell said drugs to staff personnel and to members of the public.

36. The defendants and each of them were and are aware that hospitals and other purchasers favored by defendants resell drugs to persons not confined to the hospital or other favored institution.

SECOND CAUSE OF ACTION

37. Plaintiff incorporates paragraphs 1 through 36 by reference.

38. Defendants, directly and indirectly, sell drugs to hospitals and other institutions not operated for profit on more favorable discounts, allowances, compensation, payments, services, brokerage, terms, facilities, rebates or lower prices than are available to plaintiff's assignors. Such hospitals and other institutions not operated for profit subsequently resell such

drugs to staff personnel and to members of the public who are not patients enrolled in said hospitals and other non-profit institutions.

• • • • •

(Subscription and certificate of service omitted in printing)

[R. 103]

United States District Court for the District of Oregon

PLAINTIFF'S CERTIFICATE AND STATEMENT

(Filed January 28, 1972; caption omitted in printing)

TO THE HONORABLE ROBERT C. BELLONI, CHIEF JUDGE, UNITED STATES DISTRICT COURT FOR THE DISTRICT OF OREGON

Plaintiff submits this certificate and statement pursuant to the Court's January 12, 1972 letter. The letter states in part:

> "1. Plaintiff's counsel will provide the Court with a certificate showing that they currently have information from which the Court can conclude that it is reasonably probable that discovery on the merits will produce evidence sufficient to establish each cause of action of the complaint. This statement should set forth facts now known to plaintiffs showing what each defendant did in its alleged practice of unlawful price discrimination. It would then tell the Court what it expects that discovery will reveal. Upon receipt of the certificate the Court will be able to determine whether plaintiff has more than surmise or suspicion and whether there is a reasonable likeli-

hood that discovery will produce relevant evidence. * * *"

This is a Robinson-Patman price discrimination and antitrust combination case on a matter of national importance to retail pharmacists

[R. 104]

and their customers. Customers of retail pharmacists are compelled to pay excessive prices for drugs because of discriminatory pricing practices engaged in by the defendants.

Not all drug manufacturers engage in the price discrimination alleged in the complaint and the trend is to charge retail pharmacies and other purchasers the same price and to treat everyone equally. Thus, Merck Sharp & Dohme announced on January 13, 1971 that "The prices listed for our products now apply to all customer classes: wholesalers, hospitals, retailers, chain retailers and physicians."

A harbinger of the complaint at bar is the stipulation of dismissal in *Contra Costa Pharmaceutical Association* v. *Ciba Corporation*, USDC ND Calif., No. 46218, filed November 3, 1967, which reads in part:

> "Ciba represents, subject to all defenses available to it under state or federal laws, that no free goods offers or price discounts will be made, after the date hereof, to any profit hospital or profit-making clinic which sells those goods to other than in-patients or out-patients being treated at

> such institutions unless such offers and discounts are concurrently made to all plaintiff retail pharmacists selling Ciba products in competition with such hospital or clinic."

Plaintiff incorporates by this reference its answers to defendants' numerous interrogatories.

It cannot be emphasized too strongly that the plaintiff has had no discovery while at the same time the defendants have had and continue to have the benefits of massive discovery. The latest example of this one-sided state of affairs is the compilation, *infra*, of hospital pharmacies that sell prescription drugs to persons other than in-patients.

Plaintiff's certificate and statement is voluminous because the defendants have declined to answer the complaint, filed six months ago, or the amended complaint filed in November of 1971. No defendant has answered the interrogatories filed and served on August 6, 1971.

Accordingly, plaintiff has been compelled to document matters that it expects to be admitted when the defendants finally answer the amended complaint and to be established, e.g., discriminatory pricing, when the August 6, 1971, interrogatories are answered.

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In addition to the materials presented in this statement, counsel has *Hickman* v. *Taylor*-type attorney trial-preparation materials. These trial prepara-

tion materials are available for *in camera* examination by the Court.

Plaintiff and plaintiff's counsel expect and certify that the promised discovery will confirm what is set forth in this document and is known to plaintiff's officers and members, massive and damaging price discrimination in violation of the Robinson-Patman Act.

Plaintiff's counsel certify that they expect discovery, when allowed, to establish that the defendants engage in activities that constitute a combination and concert of action prohibited by the antitrust laws, e.g., discriminatory pricing and trade practices, use of cross-licensing to violate the antitrust laws, and more than conscious price parallelism.

Each of the defendants engage in illegal price discrimination and discriminatory trade practices. Discovery will establish, for example, which of the defendants that sell directly to retail pharmacists insist on a minimum dollar amount order while at the same time not imposing a similar requirement on hospitals.

One of the more entertaining proofs of price discrimination is defendant Endo Laboratories, Inc. invoice LA 7180 dated 8/4/71, account no. 84883, to:

"BODINE CLINIC
LOGAN WALLACE PRESCRIPTIONS
1735 N. Wheeler
Portland, Oregon 97227"

Mr. Logan Wallace of Logan Wallace Prescriptions, is president of the plaintiff.

Because Endo Laboratories, Inc. considers Logan Wallace Prescriptions a "clinic," the exact word on invoice, Logan Wallace Prescriptions received two benefits given favored purchasers that are denied other retail pharmacists: the opportunity to make purchases directly from Endo Laboratories, Inc., and the opportunity to receive a discount denied

[R. 106]

other retail pharmacies. The non-favored retail pharmacies which do not receive the status of "clinic" must purchase Endo products from a wholesaler.

Invoice La 7180 lists various products (Percodan, Coumadin, Valpin and Percogestic tablets) for a total price of $424.72, less a one-sixth or 16-2/3 percent discount of $70.78 and a net billing price of $353.94. In addition, Logan Wallace Prescriptions was allowed a two percent discount for prompt payment. Endo Laboratories, Inc. accepted Logan Wallace Prescriptions check no. 1741, dated 8/16/71, in the amount of $346.86 for Invoice LA 7180.

Defendant William H. Rorer, Inc. published a retail price list for its drugs. One of the items listed is Maalox, 12 fl. oz. with a suggested list price from the wholesaler to the retailer of $1.25 and a "SUGGESTED RESALE PRICE" of $1.69. However, a Portland area discount store, "K-Mart," has been

selling Maalox, 12 fl. oz. at forty-seven cents ($.47) while the drug wholesaler's price is about $1.17.

The Warner-Chilcott Laboratories of defendant Warner-Lambert Pharmaceutical Company require a minimum order of $250 from a community pharmacy, but will sell any quantity to a non-profit hospital and require a minimum purchase of but $20 from a profit-making hospital.

Price sheets of the Bristol Laboratories Division of Bristol-Myers Company reproduced on pages A12 through A16 of volume 1 of the House Small Business Committee hearings on "Small Business Problems in the Drug Industry" reflect higher prices to retail pharmacists than to favored hospitals, e.g., the retail price for Polycyllin-N 250mg. is $1.74 to the community pharmacist but only $1.48 to hospitals. Similarly, the retail pharmacy price for Bristalin syrup 4 oz. is 60 cents; the hospital price is 50 cents.

[R. 107]

The House Small Business Committee hearings confirm that defendant Bristol-Myers Company grants hospitals substantially lower prices. Page A12 of the hearing record discloses that effective August 2, 1965, retail pharmacists were charged $8.94 for 48 capsules of Prostaphlin 250 mg. Page A30 of the hearing record reveals a December 22, 1965, Bristol-Myers hospital contract for 48 capsules of Prostaphlin 250 mg. at $4.80. The contract also listed one dose

of Staphcillin 1.00 gm. at $1.00 while retail pharmacists paid $1.91 for the same drug, according to the price list on page A12.

Various of the defendants sell drugs in Canada. It is significant, therefore, that discriminatory drug pricing in Canada was noted in "Pharmacy in a New Age," (1971), the report of the Commission on Pharmaceutical Services published by the Canadian Pharmaceutical Association.

The report said at pages 29-30:

> "Another area which seriously affects pharmacy practice is the discriminatory pricing methods which have forced community pharmacists to pay a higher price for drugs than hospitals or government, even for similar quantities. * * * In Prince Edward Island a change was made in the policy of providing anti-diebetic drugs through pharmacies to direct distribution by the government because the drugs 'were purchased from the manufacturers at greatly reduced prices.'

(no paragraph)

One firm in giving testimony to the Harley Committee explained its system of preferential prices in that it:

> 'sells some of its products to hospitals at a lower price than that charged to pharmacists. * * * We compete for the hospital business at prices which are sometimes below cost and consider this activity as part of the promotion of our products to the professional staff. * * *" (footnote omitted)

[R. 108]

Plaintiff incorporates by this reference exhibits "A" through "M" inclusive to this certificate and statement.

CONCLUSION

Plaintiff submits that this certificate and statement demonstrates that the plaintiff has ample documentary and other information from which the Court can conclude that it is reasonably probable that discovery on the merits will produce evidence sufficient to establish each cause of action of the complaint.

DATED: January 28, 1972.

(Subscription omitted in printing)

[R. 117]

EXHIBIT D TO PLAINTIFF'S CERTIFICATE AND STATEMENT

DRUG INDUSTRY RESTRICTIONS ON DRUGS

Drug industry restrictions on prescription drugs, drug industry practices and conscious price parallelism are among the factors upon which the plaintiff bases its antitrust combination count.

Several restrictive practices are set forth in Herbert D. Miller, Jr., "Patent License Restrictions in the Prescription Drug Industry," 53 Virginia L.R. 1283 (1967).

The article states at 53 Va. L.R. 1285-1286:

"As a result one might expect the prices of ethical drugs to be established by individual manufacturers largely on the basis of their cost functions, and without reference to the prices charged by competitors. Since the production and promotional costs of sellers are quite likely different, their prices should reflect this difference. However, where major producers are concerned, this is frequently not the case.

(no paragraph)

Erythromycin, a broad spectrum antibiotic patented by Abbott Laboratories in 1958, will serve as an example. In 1959 Abbott produced thirty-five per cent of the total supply, and Lilly produced sixty-five per cent. Upjohn sold, but did not produce, the compound. The prices set by these companies during the period 1959-1965 are shown below:

TABLE II

"Erythromycin, wholesale price per 100-250 *mg. tablets*

	1959	1960	1962	1963	1964	1965
Abbott (Erythrocin Stearate)	$30.60	$30.60	$26.01	$21.99	$21.99	$21.99
Upjohn (Erythromycin)	35.70	35.70	26.01	21.99	21.99	21.99
Lilly (Ilotycin)	30.60	30.60	26.01	21.99	21.99	21.99

"The prices of other patented antibiotics and tranquilizers have behaved similarly. Since the normal oligopoly explanation for this price behavior is logically inapposite, it is clear that other factors determine the price at which drugs will be sold." (footnotes omitted)

[R. 118]

The article states at 53 Va. L.R. 1290-1291:

"* * * Since production costs tend to be constant regardless of the size of the manufacturer's operation, drug patents appear to constitute the only serious obstacle to competition by small firms in this market. * * *

The patented tranquilizers purchased by the Military Supply Agency — meprobamate, promazine and chlorpromazine — have been offered at rigid prices only 25 to 35 per cent below the price to the retail druggist.

(no paragraph)

Reserpine, on the other hand, although developed by CIBA Pharmaceutical Co., has been widely licensed. * * * MMSA's first reported procurement, February 1956, was won by Eli Lilly with a bid of $1.39 per bottle of 1000, which is one twenty-fifth of Lilly's price to the druggist.

(no paragraph)

Since that time MMSA's reserpine price has steadily fallen. In February 1959, CIBA won a contract with a bid of 60 cents a bottle (only 1.5 per cent of CIBA's price to the re-

tail druggist of $39.40). And by the date of the last reported procurement, April 1960, the price had dropped to 51 cents a bottle. MMSA was buying 1000 tablets at about the cost of 15 tablets to the civilian druggist.

(no paragraph)

On one or more occasions, each of the four major sellers of this product—CIBA, Lilly, Squibb and Merck—made bids which were less than one-twentieth of their price to the retail druggists.

* * *

"The ethical drug industry has taken steps to minimize this type of competition. Since firm-name protection is ineffective in this submarket, the large scale manufacturers have utilized patent licenses to protect themselves. The remainder of this Article explores the use of the patent license to insulate large-scale drug manufacturers from competition by small producers in the institutional purchaser submarket."
(footnote omitted)

[R. 121]

EXHIBIT G TO PLAINTIFF'S CERTIFICATE AND STATEMENT

The July 5, 1971 *National Observer* contains an article titled "Foreigners Pay Less for U.S. Drugs, Study Says," and an overline that "Companies Dispute Findings," which said in part:

"A new study of drug-industry pricing prac-

tice makes melancholy reading for consumers—who annually spend $7 billion on drugs.

"The study of prices for 20 of the most widely prescribed medicines reveals that U. S. drug producers often charge more for drugs here than they do abroad—up to four times as much for identical amounts. It says that 'price discrimination' probably is the reason.

"The report contrasts average prices paid by U.S. pharmacists with the prices paid by retailers in eight other countries.

(no paragraph)

It relates, for example, that Eli Lilly & Co., exclusive distributor here of the pain killer Darvon, sells a unit of the drug to U.S. buyers for $7.02, while charging retailers in Ireland $1.66 and those in the United Kingdom $1.92 for the same unit.

* * *

"According to reports of a Senate subcommittee on monopoly, however, drug producers do not make overseas all the drugs they sell there. The manufacturers do export, often charging less for exported products than for the same medicine sold at home. Moreover, subcommittee data indicates that labor costs constitute a relatively small part of drug-making expenses even in the United States. * * *"

A chart printed with the above-quoted article lists the price findings.

Erythrocin antibiotic, manufactured by Abbott Laboratories, a defendant herein, was listed as having a United States price of $26.12, the highest of the nations surveyed, with the lowest price, of $8.56, for Ireland.

Polycillin antibiotic, manufactured by defendant Bristol-Myers Co., was listed at a U.S. price of $21.84, a Brazil price of $49.95 and a low price of $8.23 in the United Kingdom.

Wyeth's U.S. price for Equanil was $7.06 and its lowest price was $1.67 for Sweden.

Lilly's V-Cillin-K price was $8.95 in the U.S. and $2.40 in the United Kingdom.

(Certificate of service omitted in printing)

United States District Court for the District of Oregon

EXHIBIT A TO PLAINTIFF'S SUPPLEMENT TO CERTIFICATE AND STATEMENT (EXCERPT)

(Filed February 18, 1972)

[R. 170]

TABLE 1.—Comparison of seleced pharmaceutical prices in the United States and eight foreign countries, January 1970

(All prices in U. S. dollars for 100 tablets or capsules)

Generic name	Price to druggist, brand name, and manufacturer			
	United States	Australia	Brazil	Canada
Analgesic:				
Propoxyphene HCl (65 mg.)	$7.02 Darvon Lilly	$2.73 Dolozene Lilly	$3.72 Doloxene Lilly	$5.29 Darvon Lilly
Antibiotics:				
Ampicillin (250 mg.).	21.84 Poiycillin Bristol	20.48 Penbritin Bristol	41.95[2] Polycillin Bristol	22.18[3] Ampicin Bristol
Demethylchlor-tetracycline HCl (150 mg.).	19.79 Declomycin Lederle	11.17 Ledermycin Lederle	4.93 Ledermicina Cyanamid Quim do Brasil[5]	16.09 Declomycin Lederle
Erythromycin *(250 mg.)*.	26.12 Erythrocin Abbott	14.51 Erythrocin Abbott	*11.92*[1] Pantomicina Abbott	25.04 Erythrocin Abbott
Oxytetracycline HCl (250 mg.).	20.48 Terramycin Pfizer	9.79 Terramycin Pfizer	4.63 Terramicina Pfizer	16.92 Terramycin Pfizer
Potassium phenoxy-methylpenicillin (250 mg.).	8.95 V-Cillin-K Lilly	6.11 P.V.K. Lilly	8.66[1] V-Cil-K Lilly	10.69[1] V-Cillin-K Lilly
Tetracycline HCl (250 mg.).	5.34[7] Achromycin-V Lederle	9.79 Achromycin-V Lederle	4.22 Achromycin-V Cyanamid Quim do Brasil[5]	12.64 Achromycin-V Lederle
Antidepressant:				
Amitriptyline HCl (25 mg.).	8.55 Elavil Merck	3.33 Tryptanol Merck	2.26[1] Tryptanol Merck	6.30 Elavil Merck
Antidiabetic:				
Tolbutamide (500 mg.).	8.23[1] Orinase Upjhon	2.83 Rastinon Hoechst	2.77 Rastinon Hoechst	6.34[1] Orinase Hoechst

Generic name	Price to druggist, brand name, and manufacturer—Continued			
	United States	Australia	Brazil	Canada
Antihistamine:				
Diphenydramine HCl[10] (50 mg.).	2.22 Benadryl Parke-Davis	1.60[1] Benadryl Parke-Davis	.81 Benadryl Parke-Davis	2.77 Benadryl Parke-Davis
Ataraxics (tranquilizers):				
Chlordiazepoxide HCl (10 mg.).	6.40[1] Librium Roche	3.74 Librium Roche	2.40[1] Librium Roche	5.45 Librium Roche
Chlorpromazine HCl (50 mg.).	6.60 Thorazine SKF[11]	2.22 Largactil May & Baker[11]	2.47[1] Amplictil Rhodia[11]	5.82[1] Largactil Rhone-Poulenc[11]
Diazepam (5 mg.).	8.03 Valium Roche	3.74 Valium Roche	3.62[1] Valium Roche	6.01 Valium Roche
Meprobamate (400 mg.).	7.06 Equanil Wyeth	4.17 Equanil Wyeth	1.91[12] Equanil Wyeth	5.13[1] Equanil Wyeth
Prochlorperazine maleate (10 mg.).	7.86 Compazine SKF	4.44[1] Stemetil May & Baker	2.45[1] Tementil Rhodia	6.05[1] Stemetil Rhone-Poulenc[11]

Generic name	Price to druggist, brand name, and manufacturer—Continued			
	United States	Australia	Brazil	Canada
Trifluoperazine HCl (5 mg.).	9.75 Stelazine SKF	4.70 Stelazine SKF	2.42[1] Stelazine SKF	8.33 Stelazine SKF
Cardiovascular:				
Digoxin (.25 mg.).	1.03 Lanoxin B-W	.69 Lanoxin B-W	1.31[16] Digoxina B-W	1.51[17] Lanoxin B-W
Oral contraceptive:				
Ethynodial diacetate with mestranol (6x21 tabs, 1 mg.).	7.38 Ovulen 21 Searle	4.11 Ovulen 21 Searle	4.82 Ovulen 20[18] Searle	5.95[1] Ovulen 21 Searle
Sedative:				
Glutethimide (250 mg.).	3.00 Doriden Ciba	2.11 Doriden Ciba	1.97[1] Doriden Ciba	2.67 Doriden Ciba
Sulfonamide:				
Sulfisoxarole (500 mg.).	2.94 Gantrisin Roche	3.00[1] Gantrisin Roche	1.51 Gantrisin Roche	3.06 Gantrisin Roche

Generic name	Price to druggist, brand name, and manufacturer—Continued				
	Ireland	Italy	New Zealand	Sweden	United Kingdom
Analgesic:					
Propoxyphene HCl (65 mg.)	$1.66 Doloxene Lilly	$7.86[1] Doloxene Lilly	$2.08 Doloxene Lilly	$3.33 Doloxene Lilly	$1.92 Doloxene Lilly
Antibiotics:					
Ampicillin (250 mg.).	9.31 Pentrexyl Bristol	19.15[1] Sintopenyl Aesculaplus[4]	11.30[1] Penbritin Beecham	16.58 Pentrexyl Bristol	8.23 Penbritin Beecham[4]
Demethylchlortetracycline (150 mg.).	8.97[1] Ledermycin Lederle	17.88[1] Ledermicina Cyanamid[5]	3.87 Ledermycin Lederle	19.43 Ledermycin Lederle	8.20 Ledermycin Lederle
Erythromycin (250 mg.).	8.56 Erythrocin Abbott	24.57[1] Eritrocina Abbott	10.88 Official price	19.21 Erythromycin Abbott	10.02 Erythrocin Abbott
Oxytetracycline HCl (250 mg.).	7.74 Terramycin Pfizer	13.27[1] Terramicina Pfizer	3.68 Official price	13.04 Terramycin Pfizer	9.06 Terramycin Pfizer
Potassium phenoxymethylpenicillin.	2.77 Penicillin-V Lilly	([6])	2.99 Official price	([6])	2.40 V-Cil-K Lilly
Tetracycline HCl (250 mg.).	3.42 Achromycin-V Lederle	10.84[1] Acromycina Cyanamid[5]	13.78[1] Achromycin-V Lederle	13.89 Achromycin-V Lederle	5.04 Achromycin-V Lederle

Generic name	Price to druggist, brand name, and manufacturer—Continued				
	Ireland	Italy	New Zealand	Sweden	United Kingdom
Antidepressant:					
Amitriptyline HCl (25 mg.).	2.26 Tryptizol Merck	4.22[1] Triptizol Merck	4.20[3] Tryptanol Merck	3.09 Tryptizol Merck	2.28 Tryptizol Merck
Antidiabetic:					
Tolbutamide (500 mg.).	2.22[1] Rastinon Hoechst	2.86[1] Rastinon Hoechst	([9])	4.85 Rastinon Hoechst	2.28 Rastinon Hoechst
Antihistamine:					
Diphenhydramine HCl[10] (50 mg.).	1.37[1] Benadryl Parke-Davis	2.60[1] Benadryl Parke-Davis	1.29[1] Official price	2.33[1] Benadryl Parke-Davis	1.20[1] Benadryl Parke-Davis
Ataraxics (tranquilizers):					
Chlordiazepoxide HCl (10 mg.).	2.05 Librium Roche	3.55[1] Librium Roche	1.83[1] Librium Roche	3.11 Librium Roche	2.40 Librium Roche
Chlorpromazine HCl (50 mg.).	1.71[1] Largactil May & Baker	3.47[1] Largactil Farmitalia[11]	1.82[1] Official price	2.88 Largactil Rhodia	1.68[1] Largactil May & Baker
Diazepam (5 mg.).	2.46 Valium Roche	3.42[1] Valium Roche	2.72 Official price	3.71 Valium Roche	2.88 Valium Roche
Meprobamate (400 mg.).	1.79[1] Equanil Wyeth	3.65[1] Quanil Wyeth	2.06 Official price	1.67 Equanil Ferrosan[13]	1.74[1] Equanil Wyeth

Generic name	Price to druggist, brand name, and manufacturer—Continued				
	Ireland	Italy	New Zealand	Sweden	United Kingdom
Prochlorperazine maleate (10 mg.).	2.87 Stemetil May & Baker	3.04[1] Stemetil Farmitalia	2.93[1] Official price	2.28 Stemetil LEO[14]	3.04[1] Stemetil SKF
Trifluoperazine HCl (5 mg.).	2.78[1] Stelazine SKF	3.82[1] Modalina Maggioni[15]	3.71 Official price	4.41[1] Terfluzin Rhodia	2.59 Stelazine SKF
Cardiovascular: Digoxin (.25 mg.).	.53 Lanoxin B-W	1.73[1] Lanoxin Wellcome	.52[1] Official price	.98 Lanoxin B-W	.38 Lanoxin B-W
Oral contraceptive: Ethynodial diacetate with mestranol. (6x21 tabs, 1 mg.).	3.59 Ovulen 21 Searle	8.20 Ovulen Lepetit[16]	3.56 Official price	4.51 Ovulen 21 Searle	4.10 Ovulen 21 Searle
Sedative: Glutethimide (250 mg.).	.92 Doriden Ciba	1.80[1] Doriden Ciba	1.23 Official price	2.06 Doriden Ciba	1.00 Doriden Ciba
Sulfonamide: Sulfisoxarole (500 mg.).	1.64 Gantrisin Roche	2.47[1] Gantrisin Roche	1.11[1] Gantrisin Roche	2.83[1] Gantrisin Roche	1.92 Gantrisin Roche

(Footnotes and certificate of service omitted in printing)

AFFIRMATIVE DEFENSES IN DEFENDANTS' ANSWERS BASED ON 15 U.S.C. § 13c

[R. 182]

United States District Court for the District of Oregon

Answer of Defendant Endo Laboratories, Inc., to Plaintiff's Amended Complaint

(Filed October 4, 1972; caption omitted in printing)

* * * * *

[R. 184]

THIRD DEFENSE TO FIRST CAUSE OF ACTION

All sales of defendant's products to hospitals and charitable institutions not operated for profit are exempt from the Robinson-Patman Act under the provisions of 15 USC § 13(c).

* * * * *

[R. 185]

* * * * *

THIRD, FOURTH, FIFTH, SIXTH, SEVENTH AND EIGHTH DEFENSES TO SECOND CAUSE OF ACTION

Defendant incorporates herein by reference its third, fourth, fifth, sixth, seventh and eighth defenses to plaintiff's first cause of action, as though fully set forth herein.

* * * * *

[R. 188]

United States District Court for the District of Oregon

Answer of Defendant American Home Products Corporation to Plaintiff's Amended Complaint

(Filed October 4, 1972; caption omitted in printing)

* * * * *

[R. 191]

* * * * *

FIRST AFFIRMATIVE DEFENSE TO FIRST CAUSE OF ACTION

All sales of defendant's products to hospitals, and to institutions not operated for profit are exempt from the Robinson-Patman Act under the provisions of 15 USC Sec. 13c.

* * * * *

[R. 192]

* * * * *

SECOND CAUSE OF ACTION

I

Defendant realleges and incorporates herein its answers and affirmative defenses to plaintiff's first cause of action.

* * * * *

[R. 196]

United States District Court for the District of Oregon

Answer of Defendant E. R. Squibb & Sons, Inc., to Amended Complaint

(Filed October 4, 1972; caption omitted in printing)

* * * * *

FIRST CAUSE OF ACTION

* * * * *

THIRD DEFENSE

All sales of this defendant's products to schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit are exempt from the Robinson-Patman Act under the provisions of 15 U.S.C., Sec. 13c.

* * * * *

[R. 198]

* * * * *

SECOND CAUSE OF ACTION

* * * * *

SECOND, THIRD, FOURTH AND FIFTH DEFENSES

This defendant incorporates its second, third, fourth and fifth defenses to plaintiff's first cause of action.

* * * * *

[R. 201]

United States District Court for the District of Oregon

Answer of Defendant Squibb Corporation to Amended Complaint

(Filed October 4, 1972; caption omitted in printing)

* * * * *

FIRST CAUSE OF ACTION

* * * * *

[R. 202]

* * * * *

FOURTH DEFENSE

All sales of E. R. Squibb & Sons, Inc.'s products to schools, colleges, universities, public libraries, churches, hospitals and charitable institutions not operated for profit are exempt from the Robinson-Patman Act under the provisions of 15 U.S.C., Sec. 13c.

* * * * *

[R. 203]

SECOND CAUSE OF ACTION

* * * * *

SECOND, THIRD, FOURTH, FIFTH AND SIXTH DEFENSES

This defendant incorporates its second, third, fourth and fifth defenses to plaintiff's first cause of action.

* * * * *

[R. 205]

United States District Court for the District of Oregon

Answer of Defendant Eli Lilly and Company to Plaintiff's Amended Complaint

(Filed October 4, 1972; caption omitted in printing)

* * * * *

[R. 208]

* * * * *

THIRD DEFENSE TO SECOND CAUSE OF ACTION

Purchases of Lilly products by hospitals, and charitable institutions not operated for profit are exempt from the Robinson-Patman Act under 15 U.S.C. § 13c (May 26, 1938, c. 283, 52 Stat. 446).

* * * * *

[R. 212]

United States District Court for the District of Oregon

Answer of Defendant Bristol-Myers Company to Plaintiff's Amended Complaint

(Filed October 4, 1972; caption omitted in printing)

* * * * *

[R. 216]

* * * * *

THIRD DEFENSE TO SECOND CAUSE OF ACTION

All sales of defendant's products to hospitals and to institutions not operated for profit are exempt from the Robinson-Patman Act under the provisions of 15 U.S.C. § 13c.

* * * * *

[R. 220]

United States District Court for the District of Oregon

Answer of Defendant A. H. Robins Company, Incorporated to Plaintiff's Amended Complaint

(Filed October 5, 1972; caption omitted in printing)

* * * * *

[R. 222]

* * * * *

ANSWER TO SECOND CAUSE OF ACTION

* * * * *

[R. 223]

* * * * *

Fifth Defense

18. Sales of defendant Robins' pharmaceutical products to hospitals and charitable institutions not operated for profit for their own use are exempt from the Robinson-Patman Act under the provisions of 15 U.S.C. Section 13c.

* * * * *

[R. 228]

United States District Court for the District of Oregon

Answer of Defendant Abbott Laboratories

(Filed October 5, 1972; caption omitted in printing)

* * * * *

[R. 233]

* * * * *

FOR ITS THIRD AFFIRMATIVE ANSWER AND DEFENSE, Abbott alleges as follows:

I

As a matter of law, all sales by Abbott to proprietary nursing homes, hospitals and other institutions, and to hospitals and other institutions not operated for profit, as those terms are used in plaintiff's second cause of action, are within the exemption

[R. 234]

of the Non-Profit Institutions Act, 15 U.S.C. § 13(c), and are, accordingly, not cognizable under the Robinson-Patman Act.

* * * * *

[R. 237]

United States District Court for the District of Oregon

William H. Rorer, Inc. Answer to Amended Complaint

(Filed October 5, 1972; caption omitted in printing)

* * * * *

[R. 240]

* * * * *

SIXTH DEFENSE

Any price differential accorded by this defendant to the alleged favored purchasers of its products was with respect to transactions exempt from coverage of the Robinson-Patman Act pursuant to 15 USC § 13c as a sale to a hospital or charitable institution not operated for profit.

* * * * *

[R. 243]

United States District Court for the District of Oregon

Answer of Defendant Carter-Wallace, Inc.

(Filed October 5, 1972; caption omitted in printing)

* * * * *

Fourth Defense

Sales by defendant Carter-Wallace, Inc. to non-profit institutions are exempt from the Robinson-Patman Act by reason of the provisions of 15 USC § 13 (c).

* * * * *

[R. 246]

United States District Court for the District of Oregon

Answer of Defendant Warner-Lambert Company to Amended Complaint

(Filed October 5, 1972; caption omitted in printing)

* * * * *

[R. 253]

* * * * *

FIFTH AFFIRMATIVE DEFENSE

The claims of plaintiff are barred, in part, by 15 USC § 13c.

* * * * *

[R. 256]

United States District Court for the District of Oregon

Answer of Defendant Ortho Pharmaceutical Company to Amended Complaint

(Filed October 25, 1972; caption omitted in printing)

* * * * *

[R. 263]

* * * * *

FIFTH AFFIRMATIVE DEFENSE

53. The claims of plaintiff are barred, in part, by 15 USC § 13c.

* * * * *

(Subscriptions and certificates of service omitted throughout in printing)

[R. 289]

United States District Court for the District of Oregon

ORDER

(Filed October 30, 1972; caption omitted in printing)

Plaintiff's motion to prohibit destruction of documents by the defendants having been heard on October 24, 1972, and counsel appearing for all parties, it is hereby

CONSIDERED AND ORDERED that the motion be denied in its entirety.

* * * * *

(Subscription omitted in printing)

[R. 323]

United States District Court for the District of Oregon

PLAINTIFF'S SECOND SUPPLEMENTAL CERTIFICATE AND STATEMENT

(Filed December 4, 1972; caption omitted in printing)

To: The Honorable James M. Burns,
United States District Judge:

Pursuant to Judge Belloni's January 12, 1972, letter Order that the plaintiff submit a certificate and statement, the plaintiff herewith supplements its January 28, 1972 certificate of evidence and its February 18, 1972, supplement.

Exhibit A is a reprint of Senator Gaylord Nelson's documented remarks on drug price discrimination printed in the September 29, 1972 *Congressional Record*. References to various of the defendants here-

in are underlined in red. Senator Nelson concluded:

> "* * * Under the present system the American people who are paying higher prices for drugs than anyone else in the world, are being subjected to monopolistic exploitation. * * *"

DATED: December 4, 1972.

(Subscription and certificate of service omitted in printing)

[R. 339]

United States District Court for the District of Oregon

PLAINTIFF'S MOTION RE LIMITED DISCOVERY AND BRIEF IN SUPPORT OF MOTION

(Filed February 5, 1973; caption omitted in printing)

Pursuant to prior orders of the Court and Rule 30, F.R.Civ.P., and without waiving its objections to limitations on discovery, Plaintiff moves the Court for an Order that:

(1) Within 15 days of the date of this Order, each defendant shall notify plaintiff of the name of its manager, salesman or other representative residing in Oregon most knowledgeable concerning sale of the defendant's drugs to alleged "non-profit" hospitals in Multnomah, Clackamas and Washington counties;

(2) Plaintiff may take the depositions of the persons identified in response to Paragraph (1) of this Order and serve upon them the EXHIBIT A TO SUBPOENA attached to plaintiff's motion.

DATED: February 5, 1973.

(Subscription omitted in printing)

[R. 340]

BRIEF IN SUPPORT OF MOTION

Plaintiff's limited discovery to date has established that there are many unknown and disputed facts concerning the issue of drug distribution practices of alleged "non-profit" hospitals.

It is submitted that these unknown and disputed facts preclude partial summary judgment on the pending summary judgment motion.

Plaintiff's limited discovery establishes, it is submitted, that defendants have relevant evidence concerning the drug distribution practices of alleged non-profit hospitals that plaintiff has been unable to obtain from the hospital officials deposed by plaintiff.

The Exhibit A to Subpoena accompanying the motion is limited to *some* documents relevant to the pending motion for partial summary judgment, although the exhibit does not call for all of the documents the plaintiff considers should be produced, e.g., in deference to the Court's prior ruling plaintiff does not call for price information.

Defendants and their representatives resident in Oregon have evidence relevant to their pending motion, therefore, the motion should be granted.

DATED: February 5, 1973.

(Subscription and certificate of service omitted in printing)

[R. 343]

United States District Court for the District of Oregon

AFFIDAVIT OF RAYMOND L. MONTEE RE HOSPITAL DRUG PURCHASES

(Filed February 5, 1973; caption omitted in printing)

STATE OF OREGON)
County of Multnomah) ss.

I, RAYMOND L. MONTEE, being first duly sworn, depose:

I

I am the President of R. L. Montee & Associates, Incorporated, an Oregon corporation that provides specialized investigation services for the professional man, and that I have been retained by the law firm of Tilbury & Kane, counsel for plaintiff in the above-titled case.

II

Pursuant to direction I made purchases of prescription and over-the-counter drugs as a member of the public from various hospital pharmacies in Multnomah, Clackamas and Washington counties.

III

At no time in offering prescriptions to be filled or in purchasing non-prescription drugs did I represent that I was (a) an inpatient, or (2) an outpatient, or (3) a hospital employe, or (4) a physician.

[R. 344]

IV

I purchased prescriptior drugs from 11 hospital pharmacies.

V

Listed below are the names and addresses of said hospital pharmacies, the prescription number, date of purchase, and name of the prescription drug purchased. Also listed are purchases of over-the-counter drugs that do not require a prescription.

(1) Kaiser Foundation Hospital Pharmacy
5055 N. Greeley Avenue
Portland, Oregon 97217

No. 138964, 10/04/72 Stilbestrol 0.5 mg. #30

Dermaplast Spray — Small

(2) St. Vincent Hospital and Medical Center Pharmacy
9205 S. W. Barnes Road
Portland, Oregon

No. 162827, 10/09/72 (drug not identified)

No. 162828, 10/09/72 (drug not identified)

(3) Dwyer Memorial Hospital Pharmacy
420 - 32nd Street
Milwaukie, Oregon

No. 13472, 10/05/72, Benadryl 25 m

No. 13473, 10/05/72, Tetracycline 250 mg

(4) Forest Grove Community Pharmacy
1809 Maple Street
Forest Grove, Oregon

No. 67502, 10/04/72, Prednisone 5 mg

No. 67503, 10/04/72, (drug not identified)

(5) City of Roses Hospital Pharmacy
1329 S. E. Harney Street
Portland, Oregon 97202

No. 33826, 10/05/72, Hydrodiuril 50 mg.

No. 33827, 10/05/72, Coumadin 5 mg

(6) Gresham Community Hospital
5th and Beech
Gresham, Oregon 97030

No. 55458, 10/11/72, Indocin 25 mg

[R. 345]

(7) Holladay Park Hospital Pharmacy
220 N. E. Multnomah
Portland, Oregon

No. 102-202, 10/05/72, Penicillin VK 250 mg.

No. 102-203, 10/05/72, Chlortrimeton 4 mg.

(8) Portland Adventist Hospital
6040 S. E. Belmont
Portland, Oregon

No. 59798, 10/05/72, V-Cillin K 250 mg

Neosporin Ointment, NDC-81-730-88,
Net wt ½ oz

(9) Willamette Falls Community Hospital Pharmacy
15th and Division
Oregon City, Oregon 97045

No. 2538, 10/16/72, (drug not identified)

Ecotrin aspirin-analgesic, bottle, 100 tablets

(10) Willamette Methodist Convalescent Center
13021 S. E. River Road
Milwaukie, Oregon

No. 25251, 10/16/72, 30 Serpasil .1

Neoloid Castor Oil, 4 fl. oz.

(11) Woodland Park Hospital Pharmacy
10300 N. E. Hancock
Portland, Oregon

No. 56257, 10/05/72, Erythrocin 250 mg
(ABBOTT LABORATORIES)

Quelidrine cough syrup 4 fl. oz.

VI

In addition, I directed a female operative to purchase prescription drugs from four Permanente Clinic pharmacies associated with the Bess Kaiser Hospital, Portland, Oregon.

VII

Listed below are the names and addresses of said Permanente clinic pharmacies, the prescription number, date of purchase, and name of the prescription drug purchased. Also listed are purchases of over-the-counter drugs that do not require a prescription.

* * * * *

(Subscription, jurat and certificate of service omitted in printing)

[R. 425]

United States District Court for the District of Oregon

PLAINTIFF'S NOTICE, UNDER PROTEST, RE SECOND CAUSE OF ACTION "DISCOVERY"

(Filed March 12, 1973; caption omitted in printing)

To Defendants and Their Local Counsel of Record:

Please Take Notice:

Pursuant to the restrictive and other orders of the Court, and under repeated protest that said restrictions on plaintiff's discovery concerning plaintiff's Second Cause of Action were and are prejudicial to plaintiff, plaintiff has taken limited depositions concerning the drug distribution practices of 14 alleged "non-profit" hospitals in Multnomah, Clackamas and Washington counties, State of Oregon.

Said limited discovery is materially incomplete, inadequate and misleading because of the limitations imposed by the Court:

(1) Plaintiff was forbidden to inquire concerning the drug prices, terms and conditions the defendants granted to the 14 alleged "non-profit" hospitals in competition with plaintiff's assignors and other community pharmacies in the tri-county area, but which the defendants did not grant to said assignors and other community pharmacies.

[R. 426]

(2) The Court repeatedly rejected plaintiff's efforts under the Federal Rules of Civil Procedure to place in the trial court file documents in the sole and exclusive possession of defendants relevant and material to the Second Cause of Action herein and the drug distribution practices of the 14 alleged "non-profit" hospitals in competition with plaintiff's assignors and other community pharmacies for the trade and custom of retail drug purchasers in Multnomah, Clackamas and Washington counties, Oregon;

(3) The Court repeatedly rejected plaintiff's efforts under the Federal Rules of Civil Procedure to take the depositions of officers, employees and agents of defendants in sole and exclusive possession of relevant and material personal knowledge concerning the drug distribution practices of the 14 alleged "non-profit" hospitals in competition with plaintiff's assignors and other community pharmacies for the trade and custom of retail drug purchasers in Multnomah, Clackamas and Washington counties, Oregon.

Had plaintiff been allowed to obtain such evidence, said evidence would have, in all likelihood:

(1) contradicted much of the "don't know" and other self-serving denials of knowledge, including but not limited to low "estimates" of the number of drug sales to the general public, in the testimony of various hospital officials deposed by plaintiff;

(2) contained substantial relevant and material evidence proving that the 14 alleged "non-profit" hospitals regularly and consistently sell prescription and other drugs in competition with plaintiff's assignors and other community pharmacies for the trade and custom of retail drug purchasers in Multnomah, Clackamas and Washington counties, Oregon;

(3) disclosed that various of the defendants herein were long aware, prior to filing of the complaint herein in 1971, that they were selling drugs at preferentially low prices to alleged "non-profit" hospitals which, in turn, resold said drugs in violation of the

[R. 427]

15 U.S.C. 13c limitation that said drugs were exclusively "for their own use;"

(4) supported the allegations of the AFFIDAVIT OF RAYMOND L. MONTEE RE HOSPITAL DRUG PURCHASES, executed November 10, 1972, and filed February 5, 1973 as part of the open trial court file.

This Notice is *not* to be construed as an admission by plaintiff that plaintiff's discovery as to drug distribution practices of the 14 alleged "non-profit" hospitals is complete or adequate or that the "evidence" is "undisputed" for purposes of defendants' pending motion for partial summary judgment or any other purpose.

Plaintiff's discovery is incomplete and inadequate

and therefore what is in the trial court file to date is misleading and in dispute.

NOW, THEREFORE, under protest, but pursuant to orders of the Court, plaintiff herewith notifies the Court and defendants that plaintiff has taken all of the depositions it is allowed to take concerning the drug distribution practices of the 14 alleged "non-profit" hospitals, and that this Notice does not constitute waiver of any of plaintiff's rights of discovery or any other rights under the applicable statutes and the Federal Rules of Civil Procedure.

DATED: March 12, 1973.

(Subscription and certificate of service omitted in printing)

[R. 384]

United States District Court for the District of Oregon

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON SECOND CAUSE OF ACTION

(Filed March 12, 1973; caption omitted in printing)

[R. 385]

Pursuant to Rule 56(b) of the Federal Rules of Civil Procedure, defendants move for summary judgment in their favor on plaintiff's second cause of action on the ground that all transactions referred to therein are exempt from the Robinson-Patman Act under 15 U.S.C. § 13c, there is no genuine issue as to any material fact, and defendants are entitled to judgment as a matter of law.

(Subscription and certificate of service omitted in printing)

[R. 438]

United States District Court for the District of Oregon

PLAINTIFF'S RULE 56 AFFIDAVIT IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION

(Filed March 20, 1973; caption omitted in printing)

STATE OF OREGON)
County of Multnomah) ss.

I, Henry Kane, being first duly sworn, depose and say:

1. I am one of the attorneys for plaintiff, am familiar with the records of this case, conducted all of plaintiff's depositions concerning what defendants term the "threshold" issue of drug distribution practices of alleged "nonprofit" hospitals, cross-examined the three witnesses whose depositions were taken by defendants, thoroughly examined the trial court file to determine whether the record to date is "ripe" for the Court to rule on defendants' motion for summary judgment on the Second Cause of Action herein, and pursuant to Rule 56(c), F.R.Civ.P., relating to service of opposing affidavits by the party in opposition, on behalf of plaintiff herewith by affidavit oppose defendants' motion for partial summary judgment on the Second Cause of Action, and base said opposition on the incomplete, inadequate and disputed trial court file upon which defendants purport to base their motion.

[R. 439]

2. In the interest of brevity your affiant incorporates by this reference all of plaintiff's motions, memoranda, affidavits and certificates relating to discovery and the Second Cause of Action, the Court's orders in response to plaintiff's attempts to make discovery, plaintiff's affidavits concerning drug distribution practices of the 14 alleged "nonprofit" hospitals, depositions taken by the parties and their accompanying exhibits, PLAINTIFF'S NOTICE, UNDER PROTEST, RE SECOND CAUSE OF ACTION "DISCOVERY," dated and filed March 12, 1973, and plaintiff's RULE 56 AFFIDAVIT OF HENRY KANE DISPUTING ACCURACY OF "CHARTS" DEFENDANTS SUBMITTED TO THE COURT, executed and filed on March 13, 1973.

3. In the light of:

(a) the huge gaps in the record concerning the Second Cause of Action;

(b) the Court's limitations on Second Cause of Action discovery and the consequences thereof;

(c) the fact that this is a Seventh Amendment jury case;

(d) the opposing inferences that may be drawn from the incomplete, disputed record to date;

(e) the hostile hospital witnesses deposed by

plaintiff whose economic interests and the economic interests of their hospital employers are adverse to plaintiff and the Second Cause of Action;

(f) the numerous disputes between plaintiff and defendants concerning what are the relevant and material facts, and

(g) lack of many of the as yet unknown relevant and material facts, granting of defendants' summary judgment motion would be untimely and improper, conflict with numerous decisions of the Supreme Court and the United States Court of Appeals for the Ninth Circuit, and would constitute reversible error.

4. There is no resolution, agreement or stipulation between plaintiff and defendants concerning the Second Cause of Action, which incorporates

[R. 440]

the allegations of the First Cause of Action. Defendants in their respective answers to the amended complaint, for example, deny the following relevant and material allegation:

> "38. Defendants, directly and indirectly, sell drugs to hospitals and other institutions not operated for profit on more favorable discounts, allowances, compensation, payments, services, brokerage, terms, facilities, rebates or lower prices than are available to plaintiff's assignors. * * *" (Am.Comp. 10, lines 15-19)

5. There is no resolution, agreement or stipulation between plaintiff and defendants concerning the following relevant and material allegation:

> "24. The exemption given sales to schools, colleges, universities, public libraries, churches, hospitals and charitable institutions not operated for profit by 52 Stat. 446, c. 283, 15 U.S.C. § 13c, where the drugs are employed for their own use, is limited to drugs used exclusively within the confines of the purchasing institution for enrolled patients of the institutions while such patients are so confined and for no other purpose." (Am. Comp. 8, lines 13-19)

6. Defendants have *not* filed any F.R.Civ.P. 56 affidavit alleging lack of dispute concerning any relevant and material fact. The closest to complying with the spirit of Rule 56 is an affidavit concerning a summary of some, *but not all*, of the depositions taken by the parties. Not summarized for purposes of the limited affidavit were the depositions of Kaiser organization representatives. For obvious reasons the deposition summaries submitted under affidavit by defendants do *not* include the depositions of the two persons who testified to forced drug sales and the depostion of RALPH G. SESSLER taken on December 22, 1972. Mr. Sessler, the former chief pharmacist at Portland Osteopathic Hospital, testified in part:

> "Q Did these drug sales, during the period that you were Chief Pharmacist at Portland Osteopathic Hospital include sale of drugs to a physician for use in his office?
>
> "A Yes." (Sessler dep. 8, lines 20-23)

7. Various of the hospital representative witnesses deposed by your affiant were obviously hostile to plaintiff, and such hostility

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was due in part to the realization that their testimony could led to filing of complaints against their hospitals. It would appear that some of the witnesses were aware that 15 U.S.C. § 13(f) provides:

> "(f) It shall be unlawful for any person engaged in commerce, in the course of such commerce, knowingly to induce *or receive a discrimination in price* which is prohibited by this section." (emphasis supplied)

8. In addition, witnesses employed by Good Samaritan and St. Vincent Hospitals and the Kaiser organizations were represented by separate law firms that at the same time represent defendants herein.

9. One result of this double representation was that the attorney representing two defendants herein, whose firm also represented Good Samaritan Hospital, asked questions concerning documents that had not been placed in the record prior to defendants' cross-examination:

> "Q • • •
>
> "I am going to hand you a document and ask you whether it might refresh your recollection as to whether this policy relating to take home drugs for inpatients has been in effect for at least the last five years?
>
> "MR. KANE: Would you make that an ex-

hibit so we know what is being testified to?

"Whereupon the Reporter marked a 1 page document entitled Medications to Patients DEPOSITION EXHIBIT NO. 16 for identification.

"THE WITNESS: Would you repeat the question.

"Q (By MR. TRIPLETT:) I am referring to the brackets and will you read the question back?

• • •

"THE WITNESS: Yes, this particular policy on the dispensing of medications to patients, which is also from my green policy book and *I had forgotten* that item No. 9 refers to 'Inpatients leaving the hospital: • • •.'" (emphasis supplied) (Good Samaritan Alma A. Kaeser deposition, p. 47, lines 17-25; p. 48, lines 1-9)

10. Based on my familiarity with the deposition record, your affiant is of the considered belief that plaintiff would be able to, similarly,

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obtain "I had forgotten" answers from various hostile and evasive witnesses that would qualify, if not contradict, testimony on which defendants rely, were plaintiff allowed to depose defendants' employees concerning the Second Cause of Action and to obtain defendants' documents relevant to the Second Cause of Action. Even without such discovery, plaintiff was able to obtain amendments of prior testimony of David H. Fawkes, Emanuel Hospital Chief Pharmacist, concerning the sums the hospital charged the

State Public Welfare Division for drugs. See Fawkes deposition dated December 21, 1972, pp. 32-33.

11. This affidavit could be further lengthened by recitals of the disputes between the parties, based on the record, concerning relevant and material facts and the inferences and conclusions to be drawn therefrom. It is sufficient, it is submitted, to defeat defendants' motion for summary judgment on the Second Cause of Action simply to refer to the Raymond Montee affidavit, which contains evidence that Mr. Montee, as a "walk-in" member of the public purchased drugs from pharmacies of alleged "nonprofit" hospitals that sell the the [sic] general public, but whose representatives denied such sales or testified that such sales were limited or discouraged. Mr. Montee was not discouraged when he attempted to, and succeeded in his attempts to purchase prescription drugs from the following "nonprofit" hospitals:

Kaiser Foundation Hospital Pharmacy
St. Vincent Hospital and Medical Center Pharmacy
Dwyer Memorial Hospital Pharmacy
Gresham Community Hospital Pharmacy
Holladay Park Hospital Pharmacy
Portland Adventist Hospital Pharmacy
Willamette Falls Community Hospital Pharmacy
Willamette Methodist Convalescent Center
Woodland Park Hospital Pharmacy

12. Plaintiff filed the Montee affidavit on February 5, 1973, giving the defendants and each of them ample opportunity to depose Mr. Montee in an effort

to qualify or discredit his affidavit and the exhibits to his affidavit, *and* to take depositions of representatives of the above-listed hospital pharmacies in order to qualify or discredit the Montee affidavit and exhibits to said affidavit.

[R. 443]

13. Despite such opportunity, the defendants and each of them deliberately elected to allow the Montee affidavit and exhibits in all of their significance to become part of the trial court file without any attempt at challenge. In other words, the truth of the facts set forth in the Montee affidavit are accepted as true by the defendants and each of them.

14. For purposes of ruling on whether the Court has power to consider defendants' summary judgment motion, the Court must accept as established that the alleged "nonprofit" hospitals listed in the Montee affidavit:

(a) sell drugs to the general public—persons having no outpatient or other connection with the hospitals;

(b) sell drugs to the general public without any of the defensive, self-serving restrictions claimed for the listed hospitals by the deposition witnesses;

(c) have, through the testimony of their representatives, created numerous questions of disputed and relevant fact concerning

whether there are, in fact, any restrictions at all on drug sales to the public in competition with plaintiff's assignors and other community pharmacies.

15. Mr. Montee's affidavit related purchase of two prescriptions from the Holladay Park Hospital Pharmacy. Copies of the actual prescription labels and the Holladay Park Hospital Pharmacy cash receipt are Xerox-copied at page 11 of the Montee affidavit.

16. The two Holladay Park Hospital Pharmacy purchases alone create a disputed issue of material fact, for Mr. James Zeazas, Holladay Park Hospital Chief Pharmacist, testified as follows under oath on December 12, 1972:

"Q Do you have any written instructions or policies concerning who may receive drugs from your pharmacy?

"A No.

"Q Do you have any oral instructions?

[R. 444]

"A Yes, we have an oral policy.

"Q What is that, sir?

"A Well, primarily we sell only to inpatients and outpatients, employees and staff physicians, *only walk-ins, as you have referred to patients off the street, on an emergency basis.*"

"Q Have you personally ever refused to fill a legitimate prescription presented to you by a walk in?

"A Yes.

"Q When was the last such occasion?
"A Yesterday.
"Q What was the reason?
"A The reason?
"Q Yes.
"A Well, the reason primarily we don't have time. We cannot, between the three pharmacists routinely employed by the hospital, *we just don't have time to fill anything but inpatient and outpatient prescriptions.*" (emphasis supplied) (Zeazas dep. 6, lines 5-25; p. 7, line 1)

17. Only Kaiser admits sales to the general public without any restriction, and this policy is admitted by defendants in their memorandum at page 21.

18. The numerous evidentiary conflicts between the Montee affidavit and the deposition testimony, of which the above-quoted Zeazas excerpt is a typical example, are evidentiary questions for the jury after study of the demeanor of the witnesses under examination and cross-examination and, perhaps, examination by the Court, taking into account evidence of the financial incentive of the hospitals listed in the Montee affidavit to sell drugs, at a huge profit, to the general public.

19. Defendants have not seen fit in their incomplete "charts submitted to the Court on February 28, 1973, to total the drug sales and profits of the alleged "nonprofit" hospitals. Defendants have in their possession plaintiff's statistical data drawn from the depositions and exhibits that reflect the following, incomplete data:

[R. 445]

Total Drug Sales	$32,792,997
Drug Net Income	$10,155,165

20. In addition, plaintiff's computation of the percentage of profit per hospital on total reported drug sales for the periods for which data was produced disclose the following percentages:

Dwyer Memorial Hospital	42.84 percent
Emanuel Hospital	41.24 percent
Good Samaritan Hospital	44.49 percent
Gresham Hospital	60.53 percent
Bess Kaiser and related Permanente clinics	35.78 percent
Holladay Park Hospital	40.78 percent
Physicians & Surgeons Hospital	37.04 percent
Portland Adventist Hospital	38.73 percent
Portland Osteopathic Hospital	28.80 percent
Providence Hospital	36.89 percent
St. Vincent Hospital	43.00 percent
Tuality Hospital	44.22 percent
Willamette Falls Hospital	not given
Willamette Methodist Center	9.85 percent

21. The above-noted huge profits were achieved despite the fact that the hospitals sold drugs at very favorable subsidized levels to employees and physicians and the charging of "overhead" such as pro rata shares of losses from charity and cafeteria operation to drug sales.

22. Defendants' memorandum at page 18 attempts to leave the impression with the Court that Kaiser's drug prices are low, without, of course, making such a claim.

23. Any such impression is contradicted by Greenlick deposition exhibit no. 2, dated November 7, 1972:

[R. 446]

"A reassessment of the dispensing fee may be in order, particularly in view of changes in the community pharmacy pricing structure. The initiation of Phase II of President Nixon's wage and price controls resulted in the public disclosure of prescription prices. * * *

(no paragraph)

As a result, *the Kaiser claim of 'reduced' prescription prices to Health Plan members has less validity.*

(no paragraph)

When compared to independent community pharmacies, Kaiser prescription charges still appear to be substantially lower.

(no paragraph)

But Kaiser rates appear to be very comparable and sometimes higher than those charged by the 'discount' type pharmacies * * *.

(no paragraph)

These changes would appear to have a detrimental effect on the Kaiser pharmacy capture rate. * * *" (emphasis supplied) (Greenlick ex. 2-11)

24. And any such impression is further contradicted by Greenlick deposition exhibit no. 4-55, which confirmed profits much greater than those earned by community pharmacies:

"However, it was reported in the *Kaiser Medical Entities Regional Economic Analysis Report* that pharmacy net revenue as a per cent of sales for the Oregon Region in 1968 was slightly over 20 per cent. This would indicate that more than $0.60 per prescription was net profit. Both the percentage and amount are substantially higher when compared to general community drug distribution systems.

(no paragraph)

Independent retail pharmacies of similar size whose prescription income was over 75 per cent of sales reported that net profits were 7.7 per cent of sales. The average net revenue per prescription dispensed was $0.36, which was 60 per cent of that reported by Kaiser pharmacies." (emphasis supplied) (footnotes omitted)

[R. 447]

25. No citation of authority is required for the principle that long-standing interpretation of a statute by an administrative agency, although not binding on the courts, is persuasive. It is therefore significant for purposes of defendants' motion that Scott Deposition Exhibit No. 17E ruled that Kaiser's pharmacy income was considered taxable:

"During 1966 the Internal Revenue Service filed notices of proposed assessments of additional federal taxes on income aggregating approximately $1,400,000 for the three years ended December 31, 1965, against three unconsolidated service subsidiaries which are 50% owned by the Kaiser Foundation Health Plan.

(no paragraph)

The proposed assessments, which involve determination of net income from pharmacy operations, are being contested by the service subsidiaries on advice of legal counsel. * * *"

26. Defendants' lengthy but irrelevant apologia for Kaiser does not cancel out the fact that Kaiser, after conferences with the U. S. Internal Revenue Service and on the advice of its counsel, agreed to pay, and has continued to pay federal income taxes on millions of dollars in drug sales. Scott Deposition Exhibit numbers 27 through 27D reflects the calculation of taxable income on $309,585.33 in Oregon drug sales classified as "Member outpatient and casual pharmacy services." Defendants also have not referred to the evidence that Willamette Methodist Convalescent Center pays federal income taxes on certain drug sales despite its "nonprofit" status.

27. Defendants attempt to downgrade the significance of the fact that Permanente Services of Oregon, Inc., a private, *for profit* corporation under Oregon law, obtains drugs from Bess Kaiser Hospital and pays income taxes on its revenue.

28. The October 20, 1972 Scott deposition discloses that Bess Kaiser Hospital Pharmacy provides drugs for the office use of physicians in private practice as partners and employees of Permanente Clinic, a private, for profit, partnership:

[R. 448]

"Q Well, is Permanente Services of Oregon, Inc. providing any goods or services or facilities to the Permanente Clinic?

"A Yes.

"Q What would that be?

"A To the extent that an individual physician, his practice requires maintaining *a supply of pharmaceuticals for his office purposes, those drugs would be provided at locations other than Bess Kaiser Hospital by Permanente Services.*" (Scott dep. 27, lines 1-10) (emphasis supplied)

28. Permanente Services of Oregon, Inc., a private for profit corporation, purchases its drugs from Kaiser Foundation Hospitals, operator of the Bess Kaiser Hospital Pharmacy:

"Q Does Permanente Services of Oregon, Inc. purchase drugs to be distributed—from manufacturers to be distributed in the Kaiser Hospital Pharmacy?

"A Permanente Service does not purchase drugs from manufacturers.

"Q Who does?

"A Kaiser Foundation Hospitals.

"Q And then does Kaiser Foundation Hospitals transfer those drugs in some manner of bookkeeping entry to Permanente Services of Oregon, Inc.?

"A *To reflect a purchase by Permanente Services of Oregon, Inc. from hospitals.*" (emphasis supplied) (Scott dep. p. 16, lines 21-25; p. 17, lines 1-7)

29. Scott Deposition No. 17B, under "Notes to Financial Statements," implies that net profits are paid to private corporations such as Permanente Services of Oregon, Inc., and, in addition, to physicians as providers of medical services:

> "Health Plan contracts with groups of physicians and Kaiser Foundation Hospitals to provide medical and hospital care to its members. * * *
>
> *"The balance of its income is distributed to the providers of medical and hospital services in accordance with the terms of the contracts between Health Plan and the providers of such services."* (emphasis supplied)

[R. 449]

30. Plaintiff's subpoena called for the articles of incorporation, *inter alia*, of the Permanente Clinic, but what was described as the articles of partnership were not produced:

> "Q (BY MR. KANE:) Now, what is, according to my notes, Permanente Clinic?
>
> "A The Permanente Clinic is a partnership of physicians doing business in the states of Oregon and Washington.
>
> "Q Do you have the Articles of Incorporation of that?
>
> "A The Articles of Partnership, I do not have those with me at the moment, Mr. Kane." (Scott dep. 6, lines 19-23)

31. Defendants' memorandum, at page 7, by its quotation of the articles of incorporation of a Kaiser

subsidiary, implies that Kaiser does not divert assets. The prohibition quoted at page 7 of the memorandum, significantly, is *not* found in the Articles of Incorporation of Kaiser Foundation Hospitals or the Articles of Incorporation of Kaiser Foundation Health Plan of Oregon. The quotation is misleading.

32. Scott Deposition Exhibit No. 17E discloses that Kaiser revenue is used to finance, from membership and other foundation revenue, what appear to be generous pensions for Permanente Clinic physicians "in the practice of medicine for personal gain:"

> "In 1959 Kaiser Foundation Health Plan, Inc. adopted retirement plans for the benefit of physicians serving Health Plan members. * * *
>
> "Retirement plan expense for 1966 was $1,952,000. * * *"

33. Scott Deposition Exhibit No. 17 discloses that pension costs for physicians and presumably others affiliated with the Kaiser organization have increased:

> "The organizations have pension plans covering certain employees. The total pension expense for 1971 and 1970 was $2,340,700 and $1,795 * * *." [sic]

[R. 450]

34. Defendants place undue reliance on the articles of incorporation they have made an exhibit to their memorandum, implying that the Court must accept their recitals as true and may not look behind the recitals to determine whether the provisions were followed.

35. Defendants therefore err in claiming that "these exhibits establish as a matter of law that the hospitals are not operating for profit within the meaning of Section 13c" because any such allegation is rebuttable. Numerous "nonprofit" corporations have been found to be commercial, not "nonprofit." Defendants also ignore the fact that under the federal tax exemption laws an organization may have a tax exemption as a "nonprofit" organization and still be required, as was Kaiser, to pay federal income taxes on income from activities—outpatient and walk in drug sales—outside the scope of the "nonprofit" tax exemption.

36. Your affiant, therefore, denies that the articles of incorporation made an exhibit to defendants' memorandum are adhered to or are conclusive in and of themselves. In support of this allegation of a disputed, relevant and material issue of fact your affiant cites the following passage from the December 14, 1972 Scott deposition:

> "Q Now Exhibit 8, the Articles of Incorporation of Permanente Services of Oregon, Inc., identified at your prior deposition, states at page 3, and I quote, 'In keeping with the primary objectives of this corporation, the net earnings of this corporation shall be limited to and shall not exceed a reasonable return, in no event exceeding 10 percent per annum on the capital invested in the conduct of the business of this corporation.'
>
> Has this been amended to allow for the 17.5 percent figure set forth in Exhibit No. 19?

> Your Articles of Incorporation refer to return of in no event exceeding 10 percent per annum on the capital invested in the conduct of the business of this corporation, which is Permanente Services of Oregon, Inc.
>
> [R. 451]
>
> This Exhibit No. 19, refers, if I read it correctly, 17.5 percent. Now, has No. 8 been amended to allow a return of that 17.5 percent?
>
> "A I am not involved in developing or maintaining the Articles of Incorporation. I am not aware of that.
>
> "Q All right. Has the return actually paid up to that maximum of 17.5 percent?
>
> "A It has been paying it, yes, for the years since this Service Agreement has been entered into." (Scott dep. p. 41, lines 10-25; p. 42, lines 1-7)

In other words, despite the provision limiting the return to 10 percent, Kaiser consistently ignored the limitation and returned 17.5 percent.

37. Because of the Court's refusal to allow plaintiff to make discovery of evidence in the sole possession of defendants concerning the drug distribution practices of the 14 alleged "nonprofit" hospitals, plaintiff has been unable to determine whether there have been other violations of the Articles of Incorporation relied upon by defendants.

38. There is an issue of relevant and material fact concerning defendants' claim at page 6 of their mem-

orandum that the status of Permanente Services of Oregon, Inc., an Oregon for profit corporation, "has no independent significance to the present motion," because the private corporation is a separate legal entity as a matter of law and fact and pays federal income tax returns on its income.

39. There is an issue of relevant and material fact concerning defendants' claim at page 6 of their memorandum that the receipts of Permanente Services of Oregon, Inc., an Oregon for profit corporation, "are the property of Health Plan" for the following reasons: the private corporation is a separate legal entity as a matter of law and fact, its records are maintained separately and Mr. Scott, the Controller, used the term purchases in describing transfers of drugs to the clinics.

[R. 452]

See paragraph 28 of this affidavit, supra, at page 11, lines 9-22. In addition, if net profits include "receipts," the evidence is that Permanente Services of Oregon, Inc., the for profit corporation, retains the profits:

> "Q What happens to your profits after taxes for Permanente Services of Oregon, Inc.?
>
> "MR. ELLIS: You are referring to the net income figure?
>
> "MR. KANE: Yes, after taxes.
>
> "THE WITNESS: It is reflected in the net worth section of the Balance Sheet of Permanente Services.

> "Q Well, are any dividends distributed to anyone?
>
> "A No.
>
> • • •
>
> "Q Have any dividends ever been distributed?
>
> "A No, not to my knowledge.
>
> "Q What is the total paid in capital, according to your records now then for Permanente Services of Oregon, Inc.?
>
> "A $50,000.
>
> "MR. DUNN: What is the Fifty?
>
> "THE WITNESS: Common stock.
>
> "MR. PHELAN: That is the invested capital. Do you want the total capital?
>
> "MR. KANE: Yes, the total capital as shown by your latest records.
>
> "THE WITNESS: Which would include retained earnings and stock?
>
> "Q Everything.
>
> "A Combination of the two, $205,227 as of December 31, 1971.
>
> "Q What was the initial paid in capital?
>
> "A Common stock of $50,000.

[R. 453]

> "Q So, the difference between $50,000 and $205,000 is the —
>
> "A (Interposing) Retained earnings of $155,-227." (October 20, 1972 Scott dep., p. 22, lines 9-25, p. 23, lines 1-21)

If the receipts did, in fact, belong to another organization, Permanente Services of Oregon, Inc., would have no taxable income. The above excerpt, however, estab-

lishes substantial retained earnings, and the same deposition, at pages 11-12, establishes that Permanente Services of Oregon, Inc. had income of $1,062,539 in calendar 1971, net income of $31,220 before taxes, and paid $8,485 federal taxes, $1,600 State of Oregon taxes and a $100 franchise tax to the State of California. Despite the defendants' efforts to obscure the facts, the two corporations are separate and are treated separately and therefore Kaiser and the defendants are bound by the deliberate choice of Kaiser to do business as it has done.

As noted in *Perma Life Mufflers, Inc.* v. *International Parts Corp.*, 392 U.S. 134, 141-142 (1968):

> "There remains for consideration only the Court of Appeals' alternative holding that the Sherman Act claim should be dismissed because respondents were all part of a single business entity and were therefore entitled to cooperate without creating an illegal conspiracy.
>
> (no paragraph)
>
> But *since respondents Midas and International availed themselves of the privilege of doing business through separate corporations, the fact of common ownership could not save them from any of the obligations that the law imposes on separate entities.*" (emphasis added)

40. There is an issue of relevant and material fact concerning defendants' claim at page 6 of their memorandum that "PSO's operation of the pharmacies in the satellite clinics is nominal, and it is no more than a department of the Kaiser program." That allegation

is contradicted by the following excerpt from the October 20, 1972 Scott deposition:

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"Q • • • Is Permanente Services of Oregon, Inc. an administrative body of any kind?

"A No, it is not.

"Q What is it then?

"A Permanente Services of Oregon, Inc. provides pharmacy and optical supply services to members of the Kaiser Foundation Health Plan.

"Q Does it provide any other services?

"A No.

"Q Does it operate the pharmacy in the Bess Kaiser Hospital?

"A No, it does not.

"Q Does it operate any of the Kaiser Clinics?

"A *It operates what you refer to as Kaiser Pharmacies—those in the State of Oregon, other than those located at Bess Kaiser Hospital.*

"Q In other words, the various clinics that have been testified to by Mr. Pirtle as being under his supervision are operated by the Permanente Services of Oregon, Inc.?

"A *That is correct.*" (emphasis supplied) Scott dep. 7, lines 6-25; p. 8, line 1)

41. There is an issue of relevant and material fact concerning defendants' claim at page 10 of their memorandum that the volume of purely retail drug sales to members of the public—the casual or "walk-in" customers is *de minimus* [sic], occurring primarily in cases, they allege, of "emergency" and "hard-

ship." The witnesses, for reasons previously related, kept their "estimates" as low as possible, but such "estimates" are doubtful in view of their personal interest in the outcome of this phase of the litigation and are further doubtful because of the ease with which plaintiff's investigator, purchased prescription and other drugs as a casual customer without any claim of "hardship," "emergency" or other representation that would have changed the status of his purchase. Assuming, but not conceding, that

[R. 455]

that [sic] the "estimates" are relatively accurate, such continuous and regular sales are substantial as a matter of fact and as a matter of law. The issue is whether sales are made, not the number of such sales. And defendants pointedly ignore the fact that the sales are made in competition with plaintiff's assignors and other community pharmacies. Defendants also ignore the fact that the Kaiser organization makes such sales without any restriction and those sales are substantial. Scott Deposition Exhibit No. 30 states at page 3 of the "Accounting Policy" manual pertaining to pharmacy:

> "On the advice of our Legal Department, the corporation is filing both State and Federal unrelated business income tax returns. * * *"

The October 20, 1972 Scott deposition, which was not summarized by defendants and filed as an exhibit, established that Kaiser reports an ever increasing

amount of drug revenue from drug sales not covered by its "nonprofit" exemption.

In 1971 Kaiser reported gross receipts of $10,561,-398.

In 1970 Kaiser reported gross receipts of $8,769,-851.

In 1969 Kaiser reported gross receipts of $7,057,-902.

In 1968 Kaiser reported gross receipts of $4,959,-008.

In four calendar years Kaiser reported gross receipts totaling *$31,848,159* from drug sales outside the "nonprofit" organization tax exemption. And Kaiser paid federal income taxes on that revenue.

Even if only ten percent of the above total represented "walk-in" sales, the percentage is equal to $3.1 million!

42. There is an issue of relevant and material fact concerning defendants' claim that nearly 90 percent of the drugs are dispensed to "inpatients." Besides being incorrect, the statistic does not take into account the much greater casual sales of the Kaiser group. Many of the so-called "inpatient" sales include so-called "take-home" drugs that are charged to the patient's bill, but are for use following his or her discharge from the hospital, and include forced sales over

[R. 456]

protests and against the wishes of the recipients. See the Carlston and Pye depositions. Both represented forced, involuntary sales of drugs for use following discharge of the patient.

43. There is an issue of relevant and material fact concerning defendants' allegation at page 10 of their memorandum that the hospital drug sales are used primarily for the "acutely ill." At best that is simplistic, for as a general proposition only a fraction of the hospitalized are "acutely" or "seriously" or "critically" ill. Indeed, much of the drugs are in the nature of "maintenance of health" drugs, e.g., vitamins, routine pain pills, etc. It is questionable whether birth control pills are for the "acutely ill." A noticeable percentage of so-called "inpatient" drug sales represent sales of drugs to be consumed following discharge from the hospital. The users would not be discharged, presumably, if they were "acutely ill."

44. There is an issue of relevant and material fact concerning defendants' allegation at page 10 of their memorandum that the hospitals make no effort to sell drugs to the public by advertising or other promotion. Such hospitals promote the sale of their drugs for the considerable profits earned by encouraging the sale, *inter alia*, of "take-home" drugs to be used following discharge from the hospital.

45. There is an issue of relevant and material fact concerning defendants' allegation at page 11 of their memorandum that the drug distribution policies

are designed "to avoid competition with community pharmacies." Defendants ignore the Kaiser policy, of course, to sell to all buyers. Plaintiff subpoenaed written policy statements on the subject, but the alleged non-competition policies appear to be oral policies and in a number of instances are contradicted by the Montee affidavit. Moreover, sales to outpatients and other persons not hospitalized "inpatients," employees and their families, and doctors and their families constitute competition with community pharmacies. It is ridiculous to claim that the hospitals don't compete for drug sales when, in fact, they offer advantageous low, subsidized prices

[R. 457]

that the community pharmacy cannot meet. Were plaintiff allowed by the Court to make the hospital price discovery plaintiff insists is vital for proper understanding and evaluation of the Second Cause of Action and the pending motion, it would be quite manifest that the hospitals successfully and deliberately compete with community pharmacies for the retail trade of the public and the hospitals' employees, physicians, students and volunteers and their families. Because the hospitals offer prices substantially lower than the prices that can be charged by the community pharmacies, which pay the full, unsubsidized price, the hospitals are quite successful competitors, as evidenced by their substantial sales to employees, physicians and others. Sometimes the favored employees, physicians and their families pay less for a drug

than the price the drug manufacturer charges the community pharmacy. One example of competition with a community pharmacy that is one of plaintiff's assignors is contained in the AFFIDAVIT OF LOGAN WALLACE RE REFILLING OF PRIVATE DOCTOR'S OFFICE PRESCRIPTION BY PORTLAND ADVENTIST HOSPITAL, executed February 24, 1973. Another example of such competition is contained in the AFFIDAVIT OF LOGAN WALLACE RE REFILLING OF PRIVATE DOCTOR'S OFFICE PRESCRIPTION BY EMANUEL HOSPITAL PHARMACY, executed December 30, 1972. Other examples of successful taking away of drug business from a community pharmacy are exhibits 13 and 14 to the December 7, 1972, deposition of Henry Wong, Providence Hospital Chief Pharmacist.

Deposition exhibit no. 13 states:

"TO WHOM IT MAY CONCERN:

"Please do not accept any more prescriptions for Vera Narveson at Bel Air Convalescent Home as both my husband and I work at Providence Hospital and can get our prescriptions filled at a very good discount.

"Guess the nurses at Bel Air didn't understand the instructions when we brought Mother to Bel Air for care.

"Thank you so very much, but I just can't see paying the full price when we can get a discount especially when her medicines run very high. Thank you so very much.

[R. 458]

Sincerely,

/s/ Mrs. Rhymer (Avis)"

Deposition Exhibit No. 14 states:

"TO WHOM IT MAY CONCERN:

"Please continue to issue the GLYSENNID TABLETS whenever necessary to Bel Air Convalescent Home, 11850 S. W. Allen Blvd., Beaverton, Oregon. for Vera Narveson as these I can't get through Providence Hospital Pharmacy. They do not carry them.

"Thank you very much.

/s/ Mrs. C. Rhymer
(Her Daughter)"

46. There is an issue of relevant and material fact concerning defendants' allegation at page 11 of their memorandum that "Most of the hospital pharmacies are located in areas not easily accessible to the public." I categorically deny that said allegation is true; certainly plaintiff's representative, Raymond Montee, experienced no access difficulties when he purchased drugs from various hospital pharmacies. Not one of the witnesses examined and cross-examined on the "access" issue said their hospital pharmacy was inaccessible, or barred to the public, or difficult to locate. None said that a hospital employee would refuse an inquiry as to the location of the pharmacy. All of the pharmacies were in the "public" parts of the hospital, as distinct from areas restricted to employees and

physicians such as laboratories. Some of the hospital pharmacies are quite readily accessible. The Bess Kaiser Hospital Pharmacy, for example, occupies a highly visible location in the main hospital lobby a short distance from the entrance to the lobby. It is difficult, if not impossible, to avoid seeing the pharmacy. See, for example, Zeazas Deposition Exhibit No. 18. It is a sketch of the Holladay Park Hospital lobby showing the pharmacy to be located five feet from the lobby entrance. The Zeazas deposition states at page 40, lines 10-18, with respect to Exhibit No. 18:

[R. 459]

"Q With that as north, the entrance is north, so, therefore, the pharmacy then is at the east of that main entrance?

"A That is right.

"Q About how many feet from the main entrance is the pharmacy?

"A Just a few feet, five feet.

"Q Five feet from your main entrance?

"A Yes."

47. There is an issue of relevant and material fact concerning defendants' allegation at page 11 of their memorandum that drug sales to "walk-ins," persons having no association with the hospital, are forbidden or discouraged and are characteristically limited to cases of immediate need or emergency, as in the evenings and on weekends when community pharmacies are closed, and the alleged "policy" is enforced by requiring customers who are not known to

the pharmacist to identify themselves or the family member for whom a drug is purchased. I categorically deny that said allegations are true, and cite in support of said denial the unchallenged Montee affidavit, the fact that the hospital pharmacies do sell to the casual public and the further admitted fact that Bess Kaiser Hospital sells without any restrictions whatsoever.

48. There is an issue of relevant and material fact concerning defendants' allegation at page 11 of their memorandum that the volume of walk-in business is negligible and is less than one percent of total drug sales. I categorically deny that said allegations are true, and cite in support of said denial that assuming but not conceding that "walk-in" sales are less than one per cent of total drug sales, even one percent of the $32,792,997 in drug sales in the record is significant, and the figure is much higher when Kaiser's sales without restriction at its hospital pharmacy and *five* Permanente Clinic pharmacies are taken into consideration. See, for example, Exhibit No. 3 to the March 6, 1973 deposition of Robert C. Wiggin, Lincoln

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National Life Insurance Company Claim Manager, which evidence a total of *2,071* Kaiser prescriptions and 13 Willamette Community Hospital prescriptions. See Wiggin Deposition No. 4—EILEEN CUMMINS AFFIDAVIT RE RETAIL CLERKS UNION, LOCAL 1092, PRESCRIPTION DRUG PURCHASES

FROM KAISER HOSPITAL AND RELATED CLINIC PHARMACIES AND WILLAMETTE COMMUNITY HOSPITAL. By definition, none of the Kaiser prescriptions are "inpatient" hospital drug orders. Instead, they are purchases by casual "walk-in" members of the public — members of Retail Clerks Union, Local 1092 and their families. The Kaiser sales were "captive" sales because the union local required its members to purchase prescription drugs from Kaiser and other "participating" pharmacies (see Wiggin Deposition Exhibit No. 2, the Wiggin deposition, the January 3, 1973, deposition of Gordon Swope, President of Retail Clerks Union Local 1092, and the deposition taken January 12, 1973 of William C. Earhart, who administers the agreement between the union and the insurance company) if they desired to be reimbursed for 80 percent of the cost of said prescriptions. Of course they desired to be so reimbursed and therefore purchased their prescriptions from Kaiser and other "participating" pharmacies.

49. There is an issue of relevant and material fact concerning defendants' allegation at page 11 of their memorandum that "walk-in" sales are minimal. I categorically deny that allegation. The "estimates" lack foundation and are suspect, at best, because they were self-serving to protect the hospitals from possible lawsuits for violation of the Robinson-Patman Act. The weight, if any, to be given the unreasonably low estimates is a question for the jury after the jury has observed the demeanor of the witnesses under examination and cross-examination. Assuming but not conceding that "walk-in" sales are minimal, what is relevant for purposes of this litigation is that "walk-in" drug sales occurred over a period of years throughout the metropolitan area of Portland.

50. There is an issue of relevant and material fact concerning

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exclusion from defendants' allegations at page 11 of their memorandu, [sic] of the cash register computed "walk-in" drug sales reported by Kaiser for the period March 1, 1970 to September 30, 1972. Pirtle Deposition Exhibit No. 2 lists a total of *6055* "non-member," that is, "walk-in" drug sales, for the 30-month period ending September 30, 1972. That number is more than "minimal," to say the least.

50. There is an issue of relevant and material fact concerning defendants' allegation at page 11 of their memorandum that none of the hospitals "supply other markets." I categorically deny that allegation on the evidence in the record that Bess Kaiser Hospital ships drugs it receives at its receiving facility to destinations out of the State of Oregon. By definition, a market outside of this state is another market.

Counsel for defendant William H. Rorer, Inc. and counsel for the Kaiser Foundation objected to plaintiff's efforts to determine whether Kaiser Hospital in Portland shipped drugs from Portland to the State of California:

"MR. PHELAN: Before we were apprised of Mr. Ellis's representation of one of the defendants with respect to distribution of drugs, I think he has answered with respect to distribution of drugs within this area. He would certainly answer those questions, but as far as distribution outside of this area, we would ask him not to answer because we think it is outside of the scope of your examination and of the case.

"Q (BY MR. KANE:) All right, let's make a record.

Are you shipping drugs into the State of California?

"MR. PHELAN: Don't answer.

"MR. KANE: All right.

"MR. TRIPLETT: I will join in the objection.

"MR. KANE: Let the record show that the witness refused to answer on advice of counsel." (Pirtle dep. 37, lines 1-18)

The Court denied plaintiff's motion to overrule the above objection:

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"6. Paragraph (2) of plaintiff's motion, dated October 27, 1972, for an Order that Mr. Roscoe Pirtle, Chief Pharmacist, Bess Kaiser Hospital, shall answer fully and completely plaintiff's deposition questions concerning distribution of drugs from said hospital, including but not limited to whether drugs are shipped from said hospital to delivery points in the State of California, and shall produce documents called for pursuant to any Subpoena Duces Tecum relating to such

distribution, is denied, except as allowed in Paragraph 2 of this Order." (AMENDED ORDER dated December 8, 1972)

The trial court file confirms the issue of disputed relevant fact.

51. There is an issue of relevant and material fact concerning defendants' allegations at pages 11-12 of their memorandum that none of the hospitals purchase drugs for, or distribute them to, clinics or other hospitals or pharmacies "and only if a drug is needed in an emergency for immediate use will any hospital lend or sell drugs (usually at cost) to such institutions (App. 6)." I categorically deny said allegations.

The Bess Kaiser Hospital sells drugs to the Permanente *Clinic*, a for personal gain partnership of some 130 physicians practicing in the Portland area. See page 11, lines 1-22, of this affidavit, supra, re purchases of drugs by the Permanente Clinic from the Kaiser Foundation Hospitals, and paragraph 50 of this affidavit, supra.

52. There is an issue of relevant and material fact concerning defendants' allegations at page 12 of their memorandum that sales to staff physicians are small in amount and that the record shows no significant distribution of drugs to doctors' offices. I categorically deny said allegations. What is significant is that such sales occur and the record is barren concerning any prohibitions on sale of drugs to physicians for distribution and resale by the favored physicians. At Portland Osteopathic Hospital, for example, for

the ten months ending October 31, 1972 the hospital sold drugs for $4,134.54 to staff physicians, according to Matlick Deposition Exhibit No. 5. The Dwyer Memorial Hospital physician figure total was an estimated $2,000 for

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for the period ending June 30, 1972 (Lindley Ex. No. 3). Other hospitals, e.g., Emanuel Hospital and Physicians and Surgeons Hospital, include sales to physicians in the statistical data designated sales to hospital employees. The Emanuel Hospital Chief Pharmacist testified:

"BY MR. VAVROSKY:

"Q Mr. Fawkes, we have discussed the percentage breakdown of sales of drugs by the pharmacy. I understand that over 91% of your drugs are administered to inpatients in the hospital.

"A Yes.

"Q And of less than nine per cent, approximately half of those are administered to both employees and their families and staff physicians and their families, is that correct?

"A Well, half of the nine percent to employees and physicians, yes." (Fawkes dep. p. 26, lines 9-20)

Assuming the above-quoted estimates are correct, sales to physicians are more than nominal because Emanuel Hospital reported drug sales totaling *$5,114,964* for the discovery period ending November 1, 1972. Further assuming that the above estimates

are correct and that sales to physicians were half the 4½% estimate for doctors and employees, drug sales to physicians were in the neighborhood of $20,000, a not inconsiderable sum for but one of 14 alleged "non-profit" hospitals.

Physicians have every incentive to purchase their drugs for office use through the hospitals because of the difference in price between purchase from the manufacturer or wholesaler at the full, unsubsidized price and the much lower price of the hospital charged by the hospitals after sweetening the incentive with generous physician's discounts.

Mr. Ralph G. Sessler, former Portland Osteopathic Hospital Chief Pharmacist, testified of hospital drug sales to physicians for office use:

"Q During this period did you sell drugs to physicians?

"A Yes.

"Q Were there any restrictions on drugs sold to physicians?

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"A Our administrator was trying to cut that out, but there was no restrictions, no.

"Q Did these drug sales, during that period that you were Chief Pharmacist at Portland Osteopathic Hospital include sale of drugs to a physician for use in his office?

"A Yes.

"Q Did you receive any instructions or orders from your superiors concerning such drug sales to physicians for their office use?

"A There was no negative considerations if they made efforts to keep their bill paid through the office. If they fell behind in their bill in the office then he would tell me to remind them to pay the bill.

* * *

"Q Can you give me some idea of the quantity of any of those physician office use drug orders?

"A This would be a long time to recollect. There was one physician, and I don't recall his name, who quite often used our pharmacy even for shipments in from drug companies and I would have to walk around and work in there and maybe he wouldn't pick them up for three or four or five days. How that was billed or whether it had anything to do with the hospital billing, I couldn't say.

Most of the orders which I received were not significant, they would receive direct, but on occasion I had belief to think that maybe some of these things were drop shipped to the physician.

"Q What do you mean by drop shipped?

"A Well, in other words, the salesman would approach a doctor for an order and he might submit it through the hospital. * * *" (Sessler dep. p. 8, lines 14-25; p. 9, lines 1-25; p. 10, lines 1-2)

Mr. Sessler testified as follows on cross-examination:

"Q There was no effort on the part of anyone so far as you know to conceal anything about prescriptions?

"A No, no, there was no effort. In fact, you see in the original Osteopathic Hospital was a small hospital in the city and they had

a hard time getting started. There were a few doctors and *the doctors were encouraged to make as many purchases as they could through the pharmacy to offset costs.*" (emphasis supplied) (Sessler dep. 18, lines 15-25; p. 19, line 1)

There is, therefore, uncontradicted evidence in the record that various drug manufacturers made "drop shipments" to physicians through the hospital. The records of physician sales through the alleged "nonprofit" hospitals are in the possession of the defendants, and denial of discovery as to such preferential sales precludes granting of the motion for summary judgment on the Second Cause of Action.

53. There is an issue of relevant and material fact concerning defendants' allegations at page 12 of their memorandum concerning preferential sales to employees, students and staff physicians as assisting the hospitals in the effective fulfillment of their purposes. I categorically deny said allegations and assuming, but not conceding the allegations are true, they are irrelevant to the issue of whether the alleged "nonprofit" hospitals are selling drugs at retail to persons other than hospitalized inpatients in competition with plaintiff's assignors and other community pharmacies. I fail to see how such practices enable a physician to do a better job for his hospitalized inpatients. Indeed, I would question the dedication of a physician who would send patients to the hospital which gave him the best "drug deal." Plaintiff would

have no quarrel with employee "fringe benefits" were those benefits based on drugs purchased by the hospitals at the same acquisition cost paid by community pharmacies. Moreover, there is no evidence in the record, let alone any affidavit, that preferential drug prices to employees and physicians promote job affiliation and performance. A hospital employee is competent or is not competent. Whether he or she purchases drugs at half the price she would have to pay for the same drug at a community pharmacy is irrelevant to that employee's level of competence and job performance. And good motives is not a defense to violation of the antitrust laws [sic].

[R. 466]

See:

United States v. *Topco Associates, Inc.*, 405 US 596, 610-611 (1972)
Albrecht v. *Herald Company*, 390 US 145, 154 (1964)
United States v. *General Motors Corp.*, 384 US 127, 146-147 (1966)
United States v. *McKesson and Robbins, Inc.*, 351 US 305, 310 (1956)
United States v. *National Association of Real Estate Boards*, 339 US 485, 488-489 (1950)
United States v. *United States Gypsum Co.*, 333 US 364, 393 (1948)
Associated Press v. *United States*, 326 US 1, 16, n. 15 (1945)
Fashion Originators' Guild of America v. *Federal Trade Commisison*, 312 US 457, 468 (1941)

United States v. *Socony-Vacuum Oil Co.*, 310 US 150, 218 (1940)
Sugar Institute, Inc. v. *United States*, 297 US 553, 599 (1936)
Paramount Famous Lasky Corporation v. *United States*, 282 US 30, 44 (1930)
Standard Sanitary Manufacturing Company v. *United States*, 226 US 20, 49 (1912)
Washington State Bowling Proprietors Association v. *Pacific Lanes, Inc.*, 356 F2d 371, 376 (9th Cir. 1966), cert. den. 384 US 363
United States v. *Hilton Corp.*, 467 F2d 1000 (9th Cir. 1972) cert. den., Jan. 15, 1973

54. There is an issue of relevant and material fact concerning defendants' allegations at page 12 of their memorandum, unsupported by any reference to the record, that none of the hospitals divert drugs in commercial redistribution in competition with plaintiff's members. I deny the allegation on grounds that such diversion is an industry problem and that the record is blank on the subject of diversion with the exception of allegations of diversion by unidentified proprietary hospitals in PLAINTIFF'S EXCERPTS FROM DEFENDANT A. H. ROBINS COMPANY, INC. TESTIMONY RE DRUG PRICE AND PRACTICE DISCRIMINATION AGAINST COMMUNITY PHARMACIES, dated and filed February 28, 1973. This is another example of evidence in the sole possession of the defendants that should be the subject of complete discovery prior to any ruling on the pending motion.

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I further deny the allegation on the ground that the existence of "diversion" as a problem was acknowledged to a congressional committee by officials of four of the defendants herein:

(1) George R. Cain, Chairman of the Board of Directors, defendant Abbott Laboratories;

(2) Henry F. DeBoest, Vice President, defendant Eli Lilly and Co.;

(3) Robert B. Clark, President, Warner-Chilcott Laboratories of defendant Warner-Lambert Pharmaceutical Company.

Exhibit A to this affidavit consists of copies of pages from volume two of the hearings on "SMALL BUSINESS PROBLEMS IN THE DRUG INDUSTRY, House Select Committee on Small Business, 1967-68.

Mr. Cain testified:

"There has been testimony before this committee that some hospitals are able to resell pharmaceuticals to some retailers at prices which other retailers cannot obtain. *We know of only a few instances in the last several years where this practice was alleged to involve our products.* Certainly our intention is that any products which we sell to hospitals are for their own use." (page 636) (emphasis supplied)

Mr. DeBoest testified:

"A common practice in the drug business is

to allow lower prices to city, county, State, and Federal agencies, as well as nonprofit and charitable institutions, on purchases of supplies for their own use. Congress has encouraged procurement of drugs for Government agencies at lower prices and has specifically recognized the status of private charitable and educational institutions in the Nonprofit Institutions Act of 1968. That act, as you know, exempts purchases of supplies by the designated institutions for their own use from the provisions of the Robinson-Patman Act. We have tried to enable our wholesale distributors to provide pharmaceuticals to such institutions on a competitive basis by lowering the wholesaler's cost on selected Lilly items.

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"It has always been our understanding that this exemption in the Nonprofit Institutions Act was intended to apply only to supplies purchased by institutions for their own use. Previous testimony heard by this subcommittee has suggested that — in some localities, at least — institutions may be departing from the purpose of the exemption and engaging in retail sale of such supplies in competition with community pharmacies. If the subcommittee finds that, in practice, the exemption is behing [sic] extended beyond its intended purpose, Eli Lilly and Co. would support appropriate amendatory legislation to correct competitive inequities." (p. 500)

"MR. MORTON. If a hospital, in turn, has an in-house retail outlet for pharmaceutical products, which anyone can go in and use, does that

hospital have a perfect legal right to conduct such a business, as far as you know?

"Mr. DeBoest. Sir, I am not competent to state. I will defer to counsel on this.

Mr. MORTON. Your product moves through that channel, and the word 'Lilly' is on it. If a hospital is running a drugstore inside the hospital, doesn't this concern you? Let me put the question this way: At what price are they buying the pharmaceuticals? There is no recourse to the Lilly Co. if the hospital itself is in violation of the 'for its own use' clause?

"Mr. DeBoest. This is the real nucleus of the problem, the interpretation of the words 'for their own use' or the phrase 'for own use.' You say we are not concerned. Yes, we are concerned. * * *" (pp. 504-505)

—

"Mr. Potvin. Do you know of any diversion of product from direct accounts, State and Federal hospitals, and do you have any mechanism for identifying the diverted products and for preventing continuation of it?

* * *

"Mr. DeBoest. *We have heard from time to time of quantities of merchandise which were sold to hospitals entering retail channels.*

(no paragraph)

[R. 469]

When we have heard and known of this, we have approached the administrator of the hospital, pointing out the exemption to the Robinson-Patman Act and the hazard that he is taking, or someone of his staff is taking, in such a practice.

"I would say by and large we have been successful in seeing that the material stays in the own-use category." (p. 509) (emphasis supplied)

Mr. DeBoest also testified concerning sale of drugs to so-called "outpatients" and persons off the street:

"* * * But in general I think we can say that the furnishing of drugs to outpatients or to patients off the street probably results in a competitive inequity to the retailer * * *." (p. 521)

Mr. Morton testified:

"Mr. Potvin. How about hospital diversion? Have you had this problem?

"Mr. Morton. Well, I have heard many others speak on this subject here. It is, obviously, in our opinion, not a big problem. I would concur to this extent. *We have some abuse of this called to our attention,* and I think possibly we could—we have been, let's put it this way, much more diligent in this area for the past several years, possibly, than some of our competitors.

(no paragraph)

We think this is an unfair practice to the small businessman, and if it is called to our attention, which it has been on several occasions, we have taken steps to go to these institutions, and talk

to them. Usually this is satisfactory. If not, I might mention for the committee's benefit that in the year 1967 we deleted a total of nine accounts for this practice.

Mr. Dingell. These are direct sales to hospitals?

Mr. Morton. Yes, sir.

Mr. Dingell. May I ask, are these tax-supported hospitals or private hospitals?

[R. 470]

Mr. Morton. Some are, Mr. Dingell, some are not." (p. 865) (emphasis added)

Mr. Morton also testified concerning his company's anti-diversion agreement with hospitals and restrictions on sales to outpatients and members of the public:

> "Mr. Morton. May I also suggest this, Mr. Dingell. We have a form that is signed by each of these institutions stating that the merchandise purchased from us will be used for in-patients or members of the staff, internal use—Not for use outside. And we have this from each account that we sell.
>
> • • •
>
> "Mr. Dingell. Would you impose particular controls, or would it cause you particular concern, if you were to find a hospital had a retail pharmaceutical outlet on its premises?
>
> "Mr. Morton. Yes, sir.

> "Mr. Dingell. Would you impose some kind of a restriction on sales to the hospital when you had been generally giving them the hospital preferential prices that you give to hospitals?
>
> "Mr. Morton. *To the extent that they sign this agreement to use the merchandise internally, not for outpatient dispensing—not for walk-in traffic.*" (p. 866) (emphasis supplied)

Mr. Clark testified:

> "Mr. Potvin. Mr. Chairman.
>
> "What is the Warner-Chilcott policy on diversion, first as to the hospital type of diversion which you have heard discussed already today?
>
> "Mr. Clark. I have heard it discussed, Mr. Potvin. *We have had very little experience with it,* to be very honest. As a matter of fact, I cannot think of an instance where it has been brought to our attention in a way that caused me or anybody under me to take specific action.

(no paragraph)

[R. 471]

> Certainly it would be our feeling, however, that *our arrangements with hospitals contemplate selling them at a discount for their own use, and if there were diversion into the retail trade from the hospital, it would be in our opinion not in accord with our understanding with them.*
>
> "Mr. Potvin. In other words, it would be your understanding that although they might have a hospital pharmacy, it should not be actively engaged in direct competition with the community pharmacy?

"Mr. Clark. That certainly is our intention and understanding." (p. 623) (emphasis supplied)

The above-quoted testimony establishes that certain of the defendants herein "police" the alleged "non-profit" hospitals to investigate any reports of diversion into retail sales. Those investigations would be in the form of reports to superiors and memoranda of discussions between the company representatives and hospital officials. It is therefore my belief that if plaintiff were allowed to make the discovery it has requested concerning "diversion" evidence in defendants' possession the defendants would produce documentary and other evidence of "diversion" by some of the 14 alleged "nonprofit" hospitals.

55. There is an issue of relevant and material fact concerning defendants' allegation at page 13 of their memorandum that so-called "take-home" drugs "are usually a necessary convenience to the patient." I categorically deny that allegation because a patient well enough to be discharged from the hospital is usually well enough to obtain his or her drugs from a community pharmacy, in person, through a friend or relative, and in many instances, by delivery from the community pharmacy. My wife, who receives numerous medications, often receives her prescription drugs by having the pharmacy make a home delivery. I submit that any convenience to the patient is far overshadowed by the desire of the hospitals to earn large profits to support the so-called "non-revenue producing" hospital departments, as indicated by the forced

"take-home drug" sales evidenced in the Pye and Carlston

[R. 472]

depositions. The "take-home" drug charges are listed on the regular hospital bill, and the drug charges are paid automatically by the patient, his family, insurance carrier, or the state and federal welfare agencies under various welfare and medical care programs, e.g., Medicare. The temptation, therefore, is to give the patient as many "take-home" drugs as possible and add the charges to the hospital bill.

56. There is an issue of relevant and material fact concerning defendants' allegation at page 13 of their memorandum that the hospitals will not refill "take-home" prescriptions.

Kaiser, with one hospital pharmacy and five clinic pharmacies scattered through the Portland-Vancouver area, refills prescriptions for "outpatients" and others without restriction, as set forth in Greenlick deposition exhibit no. 4-40:

"Redispensing as an activity is part of the distributive function and is commonly referred to as refilling. *Redispensing is initiated by outpatient request for a previously dispensed prescription drug.* The pharmacist responsibility in this case is circumscribed by law, professional ethics and physician written or oral order. For example, *the pharmacist is permitted to redispense the prescription as many times as the physician has indicated* as long as this does not conflict with legal

regulations or with the pharmacist's professional judgment of appropriate drug use. * * *" (emphasis supplied)

Greenlick deposition exhibit No. 4-48 lists new and refill prescription growth rates by pharmacy for 1968 and 1969:

80,122 refill prescriptions in 1968
96,937 refill prescriptions in 1969
percentage of refill increase = 21.0%.

A total of *177,059* refill prescriptions for "outpatients" is substantial as a matter of fact and as a matter of law.

57. There is an issue of relevant and material fact concerning defendants' allegation at page 14 of their memorandum concerning the clinics as non-income producing departments. They do produce revenue.

[R. 473]

It should be noted in this context that "nonprofit" hospitals are largely self-supporting and the recipients of numerous federal grants. In addition, a substantial portion of all indigent persons receive paid medical care under Medicare and other state and federal programs.

Thus, we find at Greenlick deposition exhibit no. 4-46:

"A portion of Portland's indigent population is currently being provided with a prepaid drug

benefit through a program made available by the Office of Economic Opportunity.

(no paragraph)

This particular group is provided with a complete prepaid drug benefit through the Kaiser medical care system, *including all prescribed drugs, whether prescription or over-the-counter, and medical supplies.*" (emphasis supplied)

58. There is an issue of relevant and material fact concerning defendants' allegation at pages 14 and 15 that the pattern of drug distribution defendants purported to describe establishes as a matter of law that the alleged "nonprofit" hospitals purchase drugs for their own use within the meaning of 15 U.S.C. § 13c. Again, defendants ignore the overwhelming evidence in the record that the Kaiser organization sells drugs outside the 15 U.S.C. § 13c exemption, was caught doing so by the Internal Revenue Service, and was compelled to pay federal income taxes on such sales unrelated to the hospital's use.

59. Your affiant objects to defendants' reliance on the alleged functions of a modern hospital, including a quotation from a paper, on the ground and for the reason that the functions of a hospital as implied by defendants have nothing to do with the issue before the Court as posed by defendants' motion. The hospitals are not defendants. The diagnostic and treatment facilities of a hospital and the theories under which they operate are irrelevant and merely clutter the record when defendants rely on such theories.

[R. 474]

60. There is an issue of relevant and material fact concerning defendants' allegations at page 16 of their memorandum that Kaiser's drug purchases are for Kaiser's own use and are therefore exempt from the Robinson-Patman Act under 15 U.S.C. § 13c. I categorically deny that allegation.

Kaiser sells substantial quantities of drugs purchased at low, preferential prices not available to plaintiff's assignors and other community pharmacies in competition with Kaiser to:

(1) Permanente Services of Oregon, Inc., an Oregon for profit business corporation;

(2) Physicians for their office use as partners and employees of the Permanente Clinic, a partnership for personal gain;

(3) Employees and their families;

(4) "Outpatients;" and

(5) "Walk-in" customers having no connection with Kaiser.

Query: If Kaiser's drug purchases are exclusively for its own use:

(1) Why did the Internal Revenue Service insist that Kaiser pay federal income taxes on a substantial portion of its drug profits?

(2) Why did Kaiser's legal counsel recommend that Kaiser pay federal income taxes on a substantial portion of its drug profits?

(3) Why has Kaiser, since 1968, paid state and federal income taxes on a substantial portion of its drug profits?

(4) And why does Permanente Services of Oregon, Inc., an Oregon for profit business corporation, pay state and federal income taxes on its drug and other profits?

Defendants, of course, prefer to ignore the fact that Kaiser does, without protest, pay state and federal income taxes on a substantial portion of its profits from drug sales.

Defendants' reply brief, if one is filed, it is submitted, should respond to the above four questions.

[R. 475]

61. There is an issue of relevant and material fact concerning defendants' allegation at page 21 of their memorandum that Kaiser's drug sales to "walk-in" members of the general public not connected to Kaiser are "minimal." I categorically deny that allegation.

Defendants acknowledge that Pirtle deposition exhibit no. 2 lists a total of 6,055 "walk-in" drug sales during the 30-month period ending September 30, 1972. The figures were obtained from cash register records and are unchallenged.

A total of 6,055 "walk-in" drug sales is not minimal. Instead, the total represents a substantial amount of drug sales to the general public clearly outside of the 15 U.S.C. § 13c exemption.

62. There is an issue of relevant and material fact concerning defendants' allegation at page 21 of their memorandum that Pirtle deposition exhibit no. 2 shows, *inter alia*, "outpatient prescriptions dispensed to * * * nonmembers during the stated periods." I categorically deny that allegation. By definition, "nonmembers" do not receive treatment from Kaiser, hence nonmember sales cannot be and are not "outpatient" drug sales. They are "walk-in" drug sales.

Greenlick deposition exhibit no. 4-84 is a table titled:

"Relationship of Health Plan Membership to Numbers Of Prescriptions Filled by Kaiser Pharmacies."

The exhibit said:

Year	Health Plan Membership*	Prescriptions Dispensed By Kaiser Pharmacies
1960	48,800	57,100
1961	55,500	64,800
1962	59,400	74,800
1963	65,400	106,000
1964	72,400	130,300
1965	81,100	160,900
1966	86,600	186,300
1967	103,100	208,900
1968	119,300	258,100
1969	132,900	315,100

Estimates for 1970, 1975, and 1980 are not reproduced. The (*) refers to "As of year end."

[R. 476]

Greenlick deposition exhibit no. 4-48 reveals substantial drug sales to nonmember "walk-in" members of the public for the period ended December 31, 1969:

Total prescriptions dispensed	1,562,300
Health Plan membership prescriptions	824,500
TOTAL PRESCRIPTIONS DISPENSED TO NONMEMBERS	737,800

Dismissing 737,800 "walk-in" prescriptions as "minimal" would be ridiculous.

For calendar 1969 alone a total of *182,200* out of 315,100 Kaiser prescriptions were dispensed to nonmember "walk-in" customers.

Moreover, Kaiser's estimates for 1970, 1975 and 1980 reflect the expectation that "walk-in" sales will continue to increase. By 1980, for example, out of 744,000 prescriptions, only 275,000 are estimated to be member prescriptions. The remaining estimated *469,000* prescriptions would go to nonmember "walk-in" customers!

Closer in time, Greenlick deposition exhibit no. 4-84 estimates that in 1975, two years from now, health plan prescriptions would be 202,800, or less than half the 523,600 prescriptions for that approaching year. Nonmember "walk-in" prescriptions for 1975, therefore, would total *320,800!*

Referring to deposition exhibit no. 4-84, Greenlick deposition exhibit no. 4-83 says of that and related tables:

"* * * The estimates are considered to be very conservative because of these reasons."

63. There is a relevant and material issue of fact concerning defendants' allegation at page 17 of their memorandum to the effect that Kaiser to varying degrees has removed the barrier of high drug costs. I deny that allegation and refer back to pages 7, 8, and 9 of this affidavit, supra, which refer to evidence in the record of high drug profits on Kaiser drug sales based on high charges for drugs.

[R. 477]

64. There is a relevant and material issue of fact concerning defendants' allegation at page 16 of their memorandum to the effect that Kaiser provides "high-quality medical care * * *." Evidence in the record indicates that the "care" as it pertains to drugs is less than efficient.

Greenlick deposition exhibit no. 4-63 states:

"The present methods employed to order and maintain prescription and non-prescription drug stocks within the outpatient drug system are diverse and flexible, but are costly. In addition, even with the diversity and flexibility allowed, out-of-stock situations occasionally occur.

"The methods employed in ordering are also inefficient from a number of standpoints. * * *

the time for the preparation and delivery of an order varies from one to five days or more. The quantities sent are not always equal to the quantities ordered, out-of-stock situations at outlying clinic pharmacies occur upon occasion, drugs are often sent without having been priced, and drugs are never dated as to when received. * * *"

Greenlick deposition exhibits numbers 4-68 and 4-69 state:

"There is further evidence to suggest that the procedures employed for processing patient prescription renewal requests may not always be conducive to insuring a safe flow of drugs. * * *" (4-68)

"Therefore, it may be concluded that the procedures employed to monitor prescription renewal requests when more than one Kaiser pharmacy is used are ineffective for safely controlling the flow of most prescription drugs. Further, the methods employed to obtain physician authorization for renewing prescription orders are time-consuming and inefficient." (4-69)

Greenlick deposition exhibit no. 4-70 states:

"In the previous chapter, the analyses indicated that the medical care system has not organized the drug system to economically utilize its resources or to employ available technology in existing drug distributive activities. * * *"

[R. 478]

Greenlick deposition exhibit no. 4-77 states:

"The medical care system has not organized the drug system to provide drug services personalized to the specific drug needs of a patient or family. The present organization of the drug system, with little or no contact between pharmacists and patients, has resulted in impersonality and a minimal opportunity to capitalize upon the special expertise of drug system personnel in interacting, understanding and contributing to more personalized patient care, particularly involving drug services.

"Neither has there been any systematic attempts by the medical care system to coordinate the provisions of drug services as a direct input into total medical care. The drug system has not been organized to provide any systematic interaction between providers of drug services and other medical care providers or to exchange patient or drug utilization information in coordinating drug services in a patient's total medical care.

"*Accessibility*

"The medical care system has not provided the drug system with the attributes of accessibility other than meeting the quantitative demands for prescriptions generated by ambulatory patients preferring to purchase prescriptions at Kaiser pharmacies. There is evidence to suggest that the prescription services may not always be accessible where and when needed by patients. * * *"

Greenlick deposition exhibit no. 4-78 states:

"The dispensing activity is performed for anyone presenting an acceptable prescription order to any of five clinic pharmacies. However, only patients having had their original prescription dispensed at the Central Clinic pharmacy are able to obtain prescription renewals from the pharmacy system in the evenings or on Sundays.

"Evidence accumulated further indicates that the hours of pharmacy operation may not be adequate to provide acceptable patient accessibility to prescription services. The results of the patient questionnaires indicated that approximately one-third of the membership purchases only a few or none of their prescriptions from Kaiser pharmacies. Further, the members stated that hours of operation was an important reason for seeking pharmacy services from non-Kaiser pharmacies * * *."

[R. 479]

Greenlick deposition exhibit no. 4-78 states:

"The medical care system has not organized an equitable financing mechanism for prescription services utilized. The largest portion of prescription services are financed by out of pocket payment at the time of service. The pricing method employed provides a prescription charge which is generally lower than the prevailing community prescription charges. However, such a financing mechanism does not recognize that those patients who require the largest amounts of prescription drugs to maintain their health are generally those least able to afford them.

"The out of pocket method of financing prescription services may serve as a distinct barrier to patient access and efficient utilization of prescription drugs. Once the medical care system has incurred the expense of diagnosing a medical condition and determining a treatment plan involving prescribed medication, it is inconsistent and inefficient to maintain a barrier to access for drugs which may delay or prevent a patient from receiving the essential treatment. * * *"

Greenlick deposition exhibit no. 4-80 states:

"* * * during periods when prescription demand exceeded the productive capacity of the pharmacy, a waiting line of prescription orders rapidly developed, resulting in extended patient waiting times, reduced accessibility and patient dissatisfactions.

(no paragraph)

The results obtained from a patient questionnaire indicated that one primary reason for using non-Kaiser pharmacies was fast service. In addition, the most frequent general patient complaint about Kaiser pharmacies was slow service (see Appendix E, page 13, Table 22).

"The standard of care established by the medical care system has been to insure safety in the flow of drugs. *The analysis of the inpatient drug system indicated that the level of safety achieved did not constitute a professionally acceptable standard.* * * *" (emphasis supplied)

The above excerpts from an expansive investigation of the Kaiser drug distribution system, partly

financed by the federal government, is more than adequate to raise an issue of relevant and material fact.

[R. 480]

Additional authoritative indicia that the quality or lack of quality of Kaiser medical and drug care is a disputed issue is Exhibit B to this affidavit. Exhibit B, made a part of the trial court file by this reference, is a copy of the cover and article by Judity Milgrom Carnoy titled "Kaiser: You Pay Your Money and You Take Your Chances," published in 9 *Ramparts* magazine 26, November 1970.

65. There is an issue of relevant and material fact concerning defendants' allegation at page 22 of their memorandum that "walk-in" drug sales occur "infrequently" and that even if greater than testified to be [sic] witnesses other than Kaiser representatives, the number would be legally insufficient. I categorically deny said allegations.

The total drug sales in the record of drug sales by the 14 alleged "nonprofit" hospitals to "outpatients, employees, physicians for their office use, physicians for their personal use, students, volunteers, families of employees, physicians, students and volunteers, and last but not least, "walk-in" customers, is more than sufficient as a matter of fact and as a matter of law to confirm that such sales are outside of the 15 U.S.C. § 13c exemption because they are sales in competition with plaintiff's assignors and other community pharmacies.

Parenthetically, defendants persist in making a distinction between Kaiser and the remaining hospitals, described as "fee-for-service" hospitals. Kaiser charges for its various services, including services to hospitalized inpatients who are *not* members of any Kaiser health plan, as indicated by the following passage from Greenlick deposition exhibit no. 4-43:

> "The activity of pricing drug orders is classified as part of the distributive function. Drug orders to be priced fall into four categories: * * * and *non-member inpatient drugs.* * * *
>
> "*If the inpatient receiving drugs is not a member of the Health Plan,* he is charged on a cost-plus basis for each drug order received. * * *" (emphasis supplied)

[R. 481]

66. There is an issue of relevant and material fact concerning defendants' allegations at page 23 of their memorandum that the 14 alleged "nonprofit" hospitals do not advertise or solicit "walk-in" business or otherwise compete with plaintiff's assignors for sales to the public, and their pharmacy operations are successfully structured to avoid it. I categorically deny each of said allegations along with the companion allegation that "Their sales to walk-in customers are *de minimus* [sic].

The hospitals compete for sales by offering prices that community pharmacies cannot meet, to students, volunteers, employes and physicians and their families. The solicitation is in the form, among others, of policy announcements and agreements distributed to employees.

It is ridiculous to claim that the pharmacy operations of the various hospitals "are successfully structured" to avoid competition for sales when various pharmacies are located in the main lobby of the hospital or are otherwise easily accessible and do, in fact, make "walk-in" and other sales to persons not hospitalized inpatients.

Kaiser Chief Pharmacist Roscoe Pirtle makes no bones about selling drugs to the public:

> "A As a pharmacist, my understanding of the pharmacist's obligation is to fill a bona fide legal prescription from whoever presents it to them; that a pharmacist is not in a position to refuse the filling of a legally accurate document, if he has the material.
>
> "Q Well, my question is, sir, do you have any written instructions or rules governing who may purchase a drug and who may not?
>
> "A Essentially we have no rules of who may not.
>
> "Q In other words, if I happen to have a prescription in my pocket for a prescription drug, can I walk out the lobby and stop at your prescription pharmacy and if it is a legal prescription have it filled as a member of the public?
>
> "A. That is right." (Pirtle dep. p. 17, lines 17-25; p. 18, lines 1-6)

[R. 482]

67. There is a relevant and material issue of fact concerning defendants' allegation at page 24 of their memorandum that a ruling in favor of plaintiff "would render the institutions less able to perform their responsibilities."

I categorically deny said allegation.

The record is absolutely bare of any shred of "evidence" that would even tend to, let alone support, defendants' theory.

A ruling for plaintiff cannot and would not injure the 14 alleged "nonprofit" hospitals or any of them. Each hospital would continue to receive the benefit of the 15 U.S.C. § 13c "for their own use" exemption applied to hospitalized inpatient drug orders. Therefore, the hospitals would not be injured as to "inpatient" drug purchases.

Moreover, a ruling for plaintiff would *not* compel any of the hospitals to cease any of their various drug distribution practices, e.g., Kaiser's unlimited sales to the public. They could continue on as before.

The only difference would be that on other than hospitalized "inpatient" drug purchases, the hospitals would pay the same general price as the community and pharmacy [sic], less uniform quantity discounts. They could even maintain their huge profit percentages by suitable price adjustments, so how would any hospital be injured?

(Subscription and jurat omitted in printing)

[R. 483]

EXHIBIT A

SMALL BUSINESS PROBLEMS IN THE DRUG INDUSTRY

HEARINGS

before the

SUBCOMMITTEE ON ACTIVITIES OF REGULATORY AGENCIES

of the

SELECT COMMITTEE ON SMALL BUSINESS HOUSE OF REPRESENTATIVES

NINETIETH CONGRESS

pursuant to

H. Res. 53

A Resolution Creating a Select Committee to Conduct Studies and Investigations of the Problems of Small Business

---

Volume 2

Washington, D. C., August 8, 9, September 27, October 12, 1967; January 24, 25, February 13, 14, 15, 27, March 20, April 23, 1968

Printed for the use of the
Select Committee on Small Business

U. S. Government Printing Office
Washington: 1968

78-783

[R. 484]

* * * and must be signed by the representative. He is supplied a copy to keep in his possession. The policy states that failure to comply in all respects is cause for termination of employment. Samples of prescription drugs may be given only to practitioners licensed by law to prescribe them. Almost all of these products are now identified as samples right on the tablet or capsule and also on the package, and if I may, the word "sample" is spelled out, either indented on the tablet or printed. Our representatives are required to determine whether a physician can actually use the samples before they are left with him. Samples are not to be used to make trade adjustments of any kind.

There has been testimony before this committee that some hospitals are able to resell pharmaceuticals to some retailers at prices which other retailers cannot obtain. We know of only a few instances in the last several years where this practice was alleged to involve our products. Certainly our intention is that any products which we sell to hospitals are for their own use.

Dispensing of pharmaceuticals by hospital pharmacies to persons who are not inpatients of the hospital is another matter. Treatment of outpatients in hospital clinics and similar facilities is growing. Also, some doctors, for a variety of reasons, are establishing offices in or close to hospitals. Hospital pharmacies may fill prescriptions for patients of those doctors. As you have heard from several other witnesses, this is

a gray area. I believe there are some legitimate uncertainties in our industry as to the consequences of these developments. It would appear, therefore, that it might be appropriate for Congress to study the feasibility of clarifying these uncertainties in a manner satisfactory to all members of the health team.

In conclusion, I would again like to express our commendations to this subcommittee for its work in this area. I would like to offer the cooperation of Abbott Laboratories in any manner that might be helpful. I will be pleased to attempt to answer any questions that the subcommittee may have.

Thank you.

MR. DINGELL. Mr. Cain, your statement this morning from the standpoint of the small businessman is perhaps the most impressive one that we have received. I believe you and Abbott, on the basis of the facts in your testimony, deserve, the commendation of this committee. I wish you to know that.

MR. CAIN. Thank you, Mr. Chairman.

MR. DINGELL. Mr. Potvin?

MR. POTVIN. Mr. Chairman, on page 6 of your statement, Mr. Cain, you speak of your quantity discounts and you point out that you do have quantity discount prices on some products which are listed and are available to all customers, that customers may also request quotations on even larger quantities. How far do these discounts go? Could you spell it out for us in some detail, that is to say a large chain orders

a very large quantity. What would be the maximum discount they could receive?

MR. CAIN. Well, Mr. Potvin, as far as our company is concerned, and I can only speak for Abbott, here is an oddity that our marketing people have informed me of. The interesting point here is that the chain, for example, does not buy as many deals or does not buy in quantities that some of the independents do, and the reason for it is that they re * * *

* * * * *

[R. 485]

Eli Lilly & Co.'s use of independent wholesale distributors provides valuable support to many small businesses handling medical products and to the general public. Retail pharmacies and hospitals have access, within reasonable distances, to wholesale houses carrying the Lilly line. This relieves them of the financial burden and responsibility of maintaining large and complete inventories of our products. It helps to insure to the patient that he will get fresh, potent Lilly products.

An explanation of Lilly pricing policies and practice is important to a full understanding of Eli Lilly & Co.'s product distribution.

As stated earlier, Lilly sells exclusively to its wholesale distributors—with the exceptions already noted. We have no direct accounts with retail pharmacies, hospitals, physicians, or city, county, and State governments.

Our merchandise is available to all our wholesale distributors on the same terms. We have no "free goods" or promotional allowances for anyone. We give quantity prices to our wholesales distributors— on the same basis for all—by reducing their costs when they have made quantity sales to their customers.

A common practice in the drug business is to allow lower prices to city, county, State, and Federal agencies, as well as nonprofit and charitable institutions, on purchases of supplies for their own use. Congress has encouraged procurement of drugs for Government agencies at lower prices and has specifically recognized the status of private charitable and educational institutions in the Nonprofit Institutions Act of 1938. That act, as you know, exempts purchases of supplies by the designated institutions for their own use from the provisions of the Robinson-Patman Act. We have tried to enable our wholesale distributors to provide pharmaceuticals to such institutions on a competitive basis by lowering the wholesaler's cost on selected Lilly items.

It has always been our understanding that this exemption in the Nonprofit Institutions Act was intended to apply only to supplies purchased by institutions for their own use. Previous testimony heard by this subcommittee has suggested that—in some localities, at least—institutions may be departing from the purpose of the exemption and engaging in retail sale of such supplies in competition with community pharmacies. If the subcommittee finds that, in practice,

the exemption is being extended beyond its intended purpose, Eli Lilly & Co. would support appropriate amendatory legislation to correct competitive inequities.

I have tried to be responsive to areas in which the subcommittee has expressed an interest, and I shall be glad to answer questions which you may have.

(The attachments to the prepared statement follow:)

HENRY F. DEBOEST

Henry F. DeBoest is vice-president for corporate affairs of Eli Lilly and Company. He is a member of the company's Board of Directors and of the executive committee of the Board and is a director of a Lilly subsidiary, Eli Lilly International Corporation.

DeBoest joined the firm as a salesman in Eugene, Oregon, on July 25, 1932. In 1934 he was transferred to Portland, becoming manager of the Portland district in 1939. He returned to that post in 1945 after three years as a chemical warfare officer with the United States Army in World War II.

Transferred to the home office in Indianapolis on August 1, 1947, DeBoest spent four years as assistant director of the production control division. He was

* * * * *

[R. 489]

MR. POTVIN. Now, in looking at the itemized statement of All Saints Episcopal Hospital in Fort Worth, Tex., we find a long list of pharmacy charges running from November 22d to the 25th totaling $32.35. We then find three charges, one for $3, one for $1.80, and one for $6.40. It says "Take-home Drugs."

Now, it is in this area of take-home drugs and outpatient and that sort of thing that it seems to me the

community pharmacist has one of his most serious problems. Can you tell me your thoughts on this, sir?

Do you feel that a take-home drug is a sale that is made in competition with the community pharmacist?

MR. DEBOEST. Sir, that would have to be qualified with what the "take-home" drug is and the circumstances under which it was prescribed.

MR. POTVIN. Are there drugs that hospitals are allowed to give patients that community pharmacists are not allowed to sell?

MR. DEBOEST. Well, no, sir, with great exceptions. There are a few but they would not be "take-home" drugs, as I understand it. The only thing that I could visualize in the case that you are just talking about was that there might have been a paste made up to fit into the tooth socket which the physician wanted or the oral surgeon wanted especially prepared in that hospital. I would have no way of knowing. But in general I think we can say that the furnishing of drugs to outpatients or to patients off the street probably results in a competitive inequity to the retailer, and this is why we recommend an examination and ultimately a definition of what "for own use" means.

MR. BROYHILL. The bells have been rung for a quorum call of the House. We will recess at this time and reconvene at 2 p.m.

I would like to ask a few questions at that time. We can also hear from the other witness scheduled.

(Whereupon, at 12:20 p.m. the subcommittee recessed to reconvene at 2 p.m. the same day.)

AFTERNOON SESSION

MR. BROYHILL. The subcommittee will come to order.

When we recessed, we were questioning Henry F. DeBoest, vice president of Eli Lilly & Co. I believe counsel has a few more questions he would like to ask you, Mr. DeBoest. We appreciate your coming back this afternoon.

MR. POTVIN. Mr. Chairman.

Mr. DeBoest. I was pleased to note in the January 2 issue of FDC Reports that Lilly apparently is in fairly robust financial condition at this time, looking at the figures on your gross and your net and so forth. Now, in general terms have your dollar sales increased or decreased over the past 5 years?

MR. DEBOEST. Increased.

MR. POTVIN. And would that most likely be true in the New York City area?

MR. DEBOEST. Yes, I believe so.

MR. POTVIN. And how many wholesalers have you added in New York in the past 5 years?

MR. DEBOEST. I would have to check the list, Mr. Potvin. I do not know.

* * * * *

[R. 490]

MR. POTVIN. You do not, I gather, give any discount on quantity at all to your wholesalers?

MR. MORTON. That is correct, sir.

MR. POTVIN. There would be no exception based on the kind of business or source of order, or size of order; would there, sir?

MR. MORTON. Not to wholesalers, no sir.

MR. POTVIN. There would be no situation whereunder a retailer could buy direct from you?

MR. MORTON. No, sir.

MR. POTVIN. I know you have gotten into some diversion situations of the nonhospital variety. I suspect that because of pending litigation you would prefer not to discuss them at this time?

MR. MORTON. I think it would not be proper here, sir.

MR. POTVIN. How about hospital diversion? Have you had this problem?

MR. MORTON. Well, I have heard many others speak on this subject here. It is obviously, in our opinion, not a big problem. I would concur to this extent. We have some abuse of this called to our attention, and think possibly we could—we have been, let's put it this way, much more diligent in this area for the past several years, possibly, than some of our competitors. We think this is an unfair practice to the small businessman, and if this is called to our atten-

tion, which it has been on several occasions, we have taken steps to go to these institutions, and talk to them. Usually this is satisfactory. If not, I might mention for the committee's benefit that in the year 1967 we deleted a total of nine accounts for this practice.

MR. DINGELL. These are direct sales to hospitals?

MR. MORTON. Yes, sir.

MR. DINGELL. May I ask, are these tax-supported hospitals or private hospitals?

MR. MORTON. Some are, Mr. Dingell, some are not.

MR. DINGELL. With respect to the diversions which have taken place in each of those instances—were they through the hospital pharmacy, or were they directly through the property control in the hospital itself? Perhaps we can direct our questions to this.

MR. MORTON. I could not answer that completely, a hundred percent accurately, because I did not participate personally in this. But I imagine it would be through the hospital pharmacy, sir.

MR. DINGELL. Would it be an inconvenience for you to submit to the committee information as to just in a general fashion how these diversions occur in each case—whether it was through the hospital pharmacy, or whether it was right through the property controller stockroom or whatever you call it right in the hospital?

MR. MORTON. If we have this information, we will be more than happy to submit it. I do not know that

I can verify for sure where this came from.

MR. DINGELL. I am just asking for the best information that you would have available to you, sir.

MR. MORTON. Yes, sir, I would be glad to.

(This information appears at the end of this testimony.)

MR. FORREST. Might I interrupt to be sure we are in the same frame of reference, Mr. Chairman? Now, we draw a distinction between hos-

* * * * *

(Certificate of service omitted)

[R. 515]

United States District Court for the District of Oregon

RULE 56 AFFIDAVIT OF LOGAN WALLACE, PRESIDENT OF PLAINTIFF, IN OPPOSITION TO DEFENDANTS' MOTION FOR PARTIAL SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION

(Filed March 22, 1973; caption omitted in printing)

State of Oregon)
County of Multnomah) ss.

I, LOGAN WALLACE, being first duly sworn, depose and say:

1. I am a registered pharmacist licensed by the State of Oregon to practice pharmacy, a pharmacist at Logan Wallace Prescriptions, a community pharmacy located at 1735 North Wheeler Avenue, Port-

land, Oregon, an assignor in the above-titled cause, President of plaintiff, Portland Retail Druggists Association, Inc., am familiar with the trial court file and the proceedings, and am competent to make this affidavit concerning the matters stated herein.

2. I make this affidavit in opposition to defendants' motion for partial summary judgment on plaintiff's Second Cause of Action, pursuant to the provisions of F.R.Civ.P. Rule 56(e).

3. I deny defendants' contentions that defendants' sales to the 14 alleged "nonprofit" hospitals are exempt from the Robinson-Patman Act under 15 U.S.C. § 13c and that defendants are entitled to judgment as

[R. 516]

a matter of law.

4. I submit that defendants' sales to the 14 alleged "nonprofit" hospitals are in violation of the Robinson-Patman Act and outside of the 15 U.S.C. § 13c exemption to the extent that said hospitals resell defendants' drugs to other than hospitalized "inpatients."

5. There is ample evidence in the record that the alleged "nonprofit" hospitals resell drugs purchased from defendants to persons and institutions such as the private Permanente Clinic other than hospitalized "inpatients," to-wit: employees, physicians, students, volunteers and their families, physicians for their office use as physicians in practice for personal gain, plus thousands of members of the general public

known as casual "walk-in" customers. These "walk-in" customers have no connection with the hospital other than as retail drug purchasers.

6. Defendants admit such sales, but in their memorandum (1) attempt to minimize the number of non-15 U.S.C. § 13c sales and when they cannot be minimized (2) attempt to explain away their significance.

7. Defendants, therefore, have made an *issue* of the *number* of "walk-in" and other retail sales in violation of the 15 U.S.C. § 13c exemption. Moreover, the Court has indicated that it considers "numbers" to be significant in determining whether the defendants have violated the Robinson-Patman Act.

8. Because "numbers" is an issue the plaintiff must obtain discovery from a prime source of evidence concerning the magnitude of the "numbers" and related practices—the defendants themselves.

9. As a practicing pharmacist I know that defendants' representatives generally known as "detailmen," regularly and systematically visit the alleged "nonprofit" hospitals and during such visits observe and then make reports concerning their observations to their companies. The various defendants have those reports and they should be produced prior to the time the Court rules on the pending motion. Greenlick Kaiser deposition exhibit no. 4-27 describes such visits:

* * * * *

(Subscription and jurat omitted in printing)

[R. 536]

United States District Court for the District of Oregon

RULE 56 AFFIDAVIT OF HOWARD STEINBACH IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION

(Filed March 28, 1973; caption omitted in printing)

STATE OF OREGON)
County of Multnomah)ss.

I, HOWARD STEINBACH, being first duly sworn, depose and say:

1. I am a registered pharmacist licensed by the State of Oregon, a partner in the operation of three pharmacies in the metropolitan area of Portland, including the Bel Aire Pharmacy, 12020 S. W. Allen Avenue, Beaverton, Oregon 97005, an assignor in the above-titled cause, have attended various of the drug practices depositions taken by plaintiff, have read and studied defendants' memorandum in support of their motion for summary judgment on the plaintiff's Second Cause of Action, and am competent to make this affidavit concerning the matters stated herein.

2. Pursuant to F.R.Civ.P. Rule 56(e), make this affidavit in opposition to defendants' motion for partial summary judgment on the plaintiff's Second Cause of Action.

3. Based on my knowledge of the practice of pharmacy and the bulky but incomplete record of evidence in this case, I state that the

[R. 537]

14 alleged "nonprofit" hospitals and related clinic pharmacies are in direct competition with plaintiff's assignors and other community pharmacies for the retail trade and custom of individual purchasers of drugs in Multnomah, Clackamas and Washington counties, Oregon.

4. The pharmacies of the 14 alleged "nonprofit" hospitals and related clinic pharmacies serve the same trading area and customer population as plaintiff's assignors and other community pharmacies in Multnomah, Clackamas and Washington counties, Oregon.

5. The plaintiff's assignors and other community pharmacies in Multnomah, Clackamas and Washington counties, Oregon, have lost, and continue to lose, a substantial dollar volume of retail drug sales to the alleged "nonprofit" hospitals and related pharmacies with which plaintiff's assignors and other community pharmacies are in direct competition.

6. I categorically and without qualification deny defendants' attempt in their memorandum to dismiss as "de minimus" [sic] the number of prescriptions sold by the 14 alleged "nonprofit" hospitals and related clinic pharmacies and the dollar volume of sales represented by those prescriptions. They are substantial both to the hospitals and to the community pharmacies. To attempt to dismiss them as "de minimus" [sic] is contrary to the record and to the meaning of the word. Those sales and prescriptions are not a trifle.

7. Approximately one mile from the Bel Aire Pharmacy is the Beaverton Clinic unit of the Permanente Clinic. The address of the Beaverton Clinic is 4855 S. W. Western Avenue, Beaverton, Oregon 97005. It is a unit of the Permanente Clinic, a partnership of physicians for personal gain. Opened in 1969, the Beaverton Clinic is directly across the street from a major shopping center, Valu-Mart, next to a large home building material supplier, Handyman Home Center, a few blocks from another major discount shopping center, Baza'r, just off a heavily traveled major arterial highway, the Beaverton-Hillsdale Highway linking Portland and Beaverton.

[R. 538]

8. The pharmacy in the Beaverton Clinic of Permanente Clinic is located just to the right as one enters the clinic lobby, approximately twelve (12) feet from the front door. It is situated so that foot traffic leaving the elevator tends to head directly to the pharmacy. In other words, the pharmacy occupies a prominent position in the clinic lobby and is easily accessible to the general public.

9. Plaintiff's deposition of Mr. Roscoe Pirtle, Kaiser's Chief Pharmacist and the supervisor of the Beaverton and other Permanente clinics, confirmed that the Bess Kaiser Hospital pharmacy and the Beaverton and other clinic pharmacies sell prescription and over-the-counter drugs without restriction to the general public. The pharmacy in the Beaverton Clinic of Permanente Clinic is situated to encourage members of the general public to purchase drugs from the pharmacy.

10. During the past ten years the population of the Beaverton area had doubled and the number of retail drug outlets had almost doubled. When Permanente Clinic opened its Beaverton Clinic in 1969 the number of community pharmacies was adequate to serve the Beaverton area. In October of 1972, the Kaiser-Permanente health plan was extended to Tektronix, the major employer in the Beaverton area with some 6,000 Beaverton area employees.

11. Based on Beaverton Clinic prescription containers received by various community pharmacies, prior to the addition of Tektronix the Beaverton Clinic filled on the order of 100 new prescriptions daily. Based on the same criteria and evidence, six months later the Beaverton Clinic of Permanente Clinic was filling on the order of 200 new prescriptions daily.

12. Kaiser Foundation Hospitals is financing a $900,000 expansion of the Beaverton Clinic of Permanente Clinic to increase the clinic staff to 27 physicians from the present 12. On this basis the prescriptions filled by the Beaverton Clinic would increase from the present 200 per day to 450 new prescriptions per day, plus refills. This anticipated increase in prescription volume would represent a

[R. 539]

noticeable diversion of drug income and business to the Beaverton Clinic of Permanente Clinic from the community pharmacies in the Beaverton area. This diversion and loss of business could result in the closure of one or more community pharmacies in the Beaverton area that could not continue to compete with the Beaverton Clinic of Permanente because of the lower prices received by Kaiser.

13. *The Valley Times*, a weekly newspaper published in Beaverton, Oregon, said in its March 22, 1973 issue under the headline: "Addition Planned to The Permanente Clinic":

> "Contract in the amount of $900,000 was awarded last week by Kaiser Foundation Health Plan of Oregon to the successful bidder, Juhr and Sons, Portland contractors, for addition to The Permanente Clinic, Beaverton. Construction is to begin immediately.
>
> "The clinic, completed in August, 1969, is at 4855 SW Western Avenue near the Beaverton-Hillsdale Highway intersection. This first major addition will more than double capacity from 12 physicians to 27 physicians and add one optometrist, new optical shop and enlarged stat laboratory.
>
> "Extension of the parking lot to undeveloped land south of the building will accommodate 175 additional vehicles.
>
> "Enlarged facilities have become necessary due to rapid growth of Health Plan membership

> in the Beaverton area, according to Sam G. Hufford, executive vice president and regional manager."

13. Mr. Roscoe Pirtle identified Pirtle Kaiser deposition exhibits numbers 5-B and 5-C, representations of Permanente Clinic pharmacy prescription labels. Both the Pauline Lee prescription identified in Pirtle deposition exhibit no. 5-B and the Sharon Wallace prescription identified in exhibit no. 5-C had labels attached to the birth control containers stating "CLINIC SALE ONLY."

14. Mr. Pirtle testified:

[R. 540]

> "Q Now, with respect to the drug to Sharon Wallace, a sheet of paper attached to the container states, 'Clinic sale only.' Does that have any significance to you, the words, quote 'Clinic sale only?'
>
> "A Yes.
>
> "Q What does it mean, as you understand those words?
>
> "A My understanding is that it is for sale within our clinic settings.
>
> "Q And nowhere else?
>
> "A Correct.
>
> "Q I take it your answer would be the same for this prescription to Pauline Lee?
>
> "A Correct." (Pirtle dep. pp. 48-49)

Mr. Pirtle therefore admits that the pharmacies he supervises sells [sic] drugs marked "CLINIC SALE

ONLY." The two prescriptions, by definition, were not issued to hospitalized inpatients of the Bess Kaiser Hospital. They were issued to persons who, on the record, are members of the general public.

15. The Pauline Lee prescription was for Ortho Novum 1 mg (Pirtle deposition exhibit no. 5-B) and the Sharon Wallace prescription was for Ortho Novum 2 mg (Pirtle deposition exhibit no. 5-C). The instruction label attached to the Sharon Wallace prescription also identified the manufacturer as a defendant herein:

> "Ortho Pharmaceutical Corporation
> Raritan, New Jersey 08869."

16. Mr. Myron Robinson is the local representative for Ortho Pharmaceutical Corporation. Earlier this year Mr. Robinson informed me that his company stamps "CLINIC SALES ONLY" on certain packages in the Ortho line to show that the merchandise was sold to tax-supported institutions, county, state and federal, at a preferentially low price. The packages are so marked to avoid diversion to unauthorized outlets, he told me, and are sold *only* to tax-supported institutions and agencies.

[R. 541]

17. The Permanente Clinic and its clinic pharmacies are not qualified to receive "FOR CLINIC SALE" only drugs from defendant Ortho Pharmaceutical Corporation if, as Mr. Robinson informed me,

drugs so marked are distributed exclusively to tax-supported public agencies. Permanente Clinic is not a tax-supported public institution or agency. Instead, Permanente Clinic is a private partnership of physicians for personal gain.

18. Exhibit A to this affidavit is a list of pharmacies closed in the Portland area of Oregon. Titled "Portland Pharmacy Closures," the exhibit was prepared by the Oregon State Board of Pharmacy from its records. Exhibit A discloses by calendar year the number of community pharmacies in the Portland area that have gone out of business:

1972	7
1971	7
1970	11
1969	6
1967	8
1966	8
1965	7
1964	2
1963	8
1962	1
1961	4
1960	1
1959	0
1958	0
1957	2
1956	0
1955	1
1954	2

The records reflect a correlation between the growth of Kaiser group prescriptions in the early 1960's and the decline of retail pharmacies.

[R. 542]

19. Exhibit B to this affidavit is a map titled "Metro-Portland Pharmacies." Exhibit B-1 is a transparent overlay over Exhibit B. Exhibit B shows the community pharmacies that have closed in the Portland Metropolitan Area since 1950. Closures total 124, with 70 of the closures, or 57 percent, coming since 1960. Exhibit B-1 is an overlay reflecting a three-mile sphere of influence from various Kaiser and Permanente Clinic pharmacies. Exhibit B-1 discloses that only 11 of the 124 community pharmacies closed are outside of the Kaiser sphere of influence.

20. Kaiser Health Plan membership in the Portland area has grown at a steady rate from 1960 through 1969, as set forth in Greenlick Kaiser deposition exhibit no. 4-89:

1960	48,800	
1961	55,500	
1962	59,400	
1963	65,400	
1964	72,400	
1965	81,100	
1966	86,600	
1967	103,100	
1968	119,300	
1969	132,900	
1970	141,200	(estimated)

1971	152,600	"
1972	164,500	"
1973	176,800	"
1974	189,600	"
1975	202,800	"

Kaiser's estimates for growth since 1969 were conservative, as indicated by the year end figures listed in Scott Kaiser deposition exhibit no. 24: 145,568 for 1970, 158,010 for 1971, and 175,385 as of November 30, 1972.

[R. 543]

21. The number of community pharmacies in the Portland area in relation to the growth of the Kaiser pharmacy operation beginning in 1963 is fairly constant. Kaiser alone did not eliminate these community pharmacies. However, the effect of Kaiser's competition and the competition of other alleged "nonprofit" hospitals using lower drug acquisition costs and nonprofit status, was to remove the profitability from the unfortunate community pharmacies forced to close. Profitability is the vital factor. With profitability removed, the community pharmacy could not be sold, remaining open was not feasible, and closure resulted.

22. The competition of the Beaverton Clinic and other alleged "nonprofit" hospitals is reflected in the following random calculations based on actual prescription containers:

(a) The Beaverton Clinic of Permanente issued prescription no. BT 131,719 on January 25, 1973

and prescription no. BT 133,257 on February 3, 1973, or a total of *1,538 prescriptions during a 10-day period;*

(b) St. Vincent Hospital issued prescription no. 150,328 on December 17, 1971, and prescription no. 167,039 on January 23, 1973, or a total of *16,711 prescriptions during a 13-month period;*

(in contrast, the Bel Aire Pharmacy that competes with St. Vincent and other alleged "nonprofit" pharmacy operations, serially numbered 9,826 new prescriptions during the period that St. Vincent numbered 16,711 new prescriptions;)

(c) Emanuel Hospital issued prescription no. 530,053 on December 12, 1972, and prescription no. 531,458 on December 25, 1972, or a total of *1,405 prescriptions during a 14-day period;*

(d) Good Samaritan Hospital issued prescription no. 170,569 on August 2, 1972, and prescription no. 174,436 on December 9, 1972, or a total of *3,867 prescriptions during a four-month period.*

The above figures reflect the competition for retail trade of the alleged "nonprofit" hospitals and help explain pharmacy closures.

[R. 544]

23. There is an issue of relevant and material fact concerning defendants' allegation at page 23 of their memorandum that "The record shows no significant distribution of drugs to doctors' offices." That

statement is contrary to the record, which shows diversion to physicians' offices, including substantial diversion of drugs purchased by Kaiser at preferential prices to the offices of Permanente Clinic physicians, a partnership of physicians for private gain. Defendants at some expense took the depositions of three Kaiser witnesses, one from New York and the two others from Oakland, California, but made no attempt to deny that the Permanente Clinic physicians received drugs from Kaiser. A limited amount of data is found in Greenlick deposition exhibit no. 4-51. The exhibit indicates that drugs with a total cost of $25,607 were transferred in 1968 to the various Portland area Permanente clinics. The comparable drug transfer cost in 1969 totaled $65,923, or more than twice the 1968 figure. And, of course, the Court denied plaintiff's motion to obtain discovery concerning Kaiser's shipments of drugs received in Portland to points outside the state of Oregon. The objections to the proposed discovery indicates that someone had something to hide. Not until plaintiff is allowed to make proper and complete discovery, will the record show whether or not sales to physicians for their office use and other diversion has, in fact, occurred. Much of that evidence is in the sole possession of defendants, invoices and shipping orders reflecting "drop shipments" direct to physicians and others using preferential hospital prices, that are not reflected in hospital records and may not even be known to the witnesses deposed by plaintiff. See the Ralph Sessler deposition:

"Q Can you give me some idea of the quantity of any of those physician office use drug orders?

"A * * * How that was billed or whether it had anything to do with the hospital billing, I couldn't say.

[R. 545]

"Most of the orders which I received were not significant, *they would receive direct, but on occasion I had belief to think that some of these things were drop shipped to the physician.*

"Q What do you mean by drop shipped?

"A Well, in other words, *the salesman would approach a doctor for an order and he might submit it through the hospital.* My orders had to go through. I had to use a purchase order and in other words, if there was billing to them and I didn't initiate a purchase order, then it would have to have been taken care of through the office and not within my knowledge, but, of course, this again is surmised." (Sessler deposition p. 11, lines 11-25, p. 12, lines 1-6) (emphasis supplied)

Mr. Sessler also testified:

"Q There was no effort on the part of anyone so far as you know to conceal anything about prescriptions?

"A No, no, there was no effort. In fact, you see in the original Osteopathic Hospital was a small hospital in the city and they had a hard time getting started. There were a few doctors and *the doctors were encouraged to make as many purchases as they could through the pharmacy to offset costs.*

"It had become an outmoded custom and as I say, Mr. Chambers, the Administrator who was there, and he is dead now, he wished to discourage it, he did not want to carry doctor bills through the hospital on his books and had narrowed it down to a point where if they were not prompt in payment he would tell me to get them to pay up and discourage this, you know." (Sessler deposition p. 18, lines 15-25, p. 19, lines 1-8) (emphasis supplied)

Mr. Ronald Allen Bremner, Portland Osteopathic Hospital Chief Pharmacist confirmed the testimony of Mr. Sessler:

"Q Now, you mentioned drugs to doctors' offices.

What did you mean by that, sir?

"A Well, this is office supplies, like antibiotics, a shot of pencillin or something—if a patient comes in and has gonorrhea or syphilis, something like that, they will

[R. 546]

give them a shot of pencillin right in the office, and these are more or less office supplies they pick up.

* * *

"Q Do you ship the drugs that go to doctors for their office use by mail or how is it physically transferred?

"A They pick them up at the pharmacy.

"Q Is the package wrapped up?

"A No.

"Q How is it done?

"A They come in and order the items they want and you just give it to them." (Bremner deposition p. 7, lines 18-24; p. 9, lines 8-15)

Mr. Milo Haas, Director of Pharmacy Services for Dwyer Memorial Hospital, testified:

"Q What were the specialty items that were referred to earlier?

"A Types of refilled syringes, injectable, that would be needed — sometimes like 2.8 units of penicillin that would be needed immediately.

"Q Well, is this for the personal consumption by the physician?

"A That type, no, it would not be.

"Q What is that category used for?

"A Probably be used for doctor's office practice.

"Q And that is what specialty items are?

"A That is a specialty. Like another specialty would be something like a catheter, which are a prescription item, and basically are supplied by the pharmacy.

"Q These items, I take it, are available from the wholesaler or the manufacturer by anyone who is eligible to purchase them?

"A Yes, any pharmacy could."

(Haas deposition p. 4, lines 20-25; p. 5, lines 1-10)

[R. 547]

Mr. Charles Ferrell, Willamette Falls Hospital Chief Pharmacist, testified:

"Q (By Mr. Kane) What is your pricing policy on sales to physicians?

"A Generally at our invoice price. We don't pass on our discount to the physician.

"Q Just invoice price and nothing else?

"A Right. For example, we don't sell — let me put it this way, we sell very little to physicians. On occasions we, on case prices we get a 10 percent discount and *we charge the physician the invoice price* and do not pass on the discount, but our dollar volume to physicians is very small.

* * *

"Q What restrictions, if any, do you have?

"A *There have been no restrictions.* It has not been a problem.

"Q Does that mean you will fill an order for a physician for drugs for his office use?

"A No. It has happened probably five times in two years.

"Q What has happened?

"A That *we have taken orders or sold merchandise to a doctor for his office use.*

"Q What type of drug merchandise?

"A Local anesthetic.

"Q Anything else?

"A Injectables.

"Q Anything else?

"A No.

"Q Are these injectables materials that are available from a wholesaler?

"A Yes." (Ferrell deposition p. 9, lines 6-16; page 10, lines 2-19) (emphasis supplied)

Mr. Joseph Clarence Chartier, Gresham Community Hospital Chief Pharmacist, testified:

[R. 548]

"Q Does the hospital sell drugs to physicians for their office use?

"A In a very, very, very limited quantity.

"Q What do you mean by very limited?

"A * * * We do have some physicians not associates, excuse me, but they do have their offices in our hospital and one of them purchases some items from me, 90% of which are for his wife's personal use.

"Q *Does that mean that say 10 percent is for his office use in the hospital?*

"A That is right."

(Chartier deposition p. 10, lines 22-25; p. 11, lines 3-9)

Mr. James Zeasas, Holladay Park Hospital Chief Pharmacist, testified:

"Q Now, do you sell prescription drugs to physicians other than for their own personal consumption?

"A Other than for their own personal use?

"Q Yes, say their office supplies?

"A On occasion.

"Q What are the circumstances?

"A Well, there are many drugs that drug stores don't carry, many injections that drug stores don't carry. Some of the antimetabulites for cancer are only available through a hospital pharmacy?

"Q Why is that, sir?

"A Well, I don't think that a drug store would stock it. I don't see why they would.

"Q There is no legal restriction?

"A No, there is no legal restrictions." [sic]

(Zeasas deposition p. 18, lines 6-20)

Mr. Henry Wong, Providence Hospital Chief Pharmacist, testified:

"Q Now, with respect to sales of prescription drugs to your staff physicians, do you place any restrictions on the amount of drugs that the physician may purchase?

"A No. You mean how much can they buy?

[R. 549]

"Q Yes.

"A No." (Wong deposition p. 22, lines 22-25; p. 23, lines 1-2)

Mr. Conrad M. McConnell, St. Vincent Hospital Director of Pharmacy, testified:

"Q Now, do you sell drugs to physicians on the staff of the hospital?

"A Occasionally we have.

"Q Do you have any instructions concerning limitations on sale of drugs to physicians?

"A No, not instructions.

"Q No instructions at all?

"A No."

(McConnell deposition p. 19, lines 3-10)

24. There is an issue of relevant and material fact as to whether the alleged "nonprofit" hospitals that sell drugs at preferentially low prices to physicians, employees, students, volunteers and the families of same are in violation of the rules of the Public Welfare Division of the State of Oregon. Rule no. 4 of the

division's drug guidelines, applicable to the "non-profit" hospitals, states:

"The price to be paid by the Public Welfare Division for any drug in the lists of Basic Drugs set forth in this guide will be billed by the pharmacist at the *lesser of:*

1. The ceiling price quoted in the Basic Drug lists; *or*

2. The usual and customary charge by the pharmacist to the general public.

"NOTE: 'General public' means more than the pharmacist's total customer load. The term includes an identifiable group such as an association, society or organization of persons having a common interest; number of persons forming a recognizable unit; number of persons classified or gathered together because of common interest, characteristics, or community of interest; persons covered under an insurance plan; 'Prescription Club' members; etc.

(no paragraph)

[R. 550]

If drugs are dispensed to persons in these groups at prices less than the ceiling prices payable by the Public Welfare Division, as a tax-supported agency, they should be billed for at the lesser amounts."

See Fawkes deposition exhibit no. 12, titled "STANLEY HARTMAN AFFIDAVIT RE EMANUEL HOSPITAL DRUG DISTRIBUTION PRAC-

TICES." Paragraph VIII of Fawkes deposition exhibit no. 12 referred to an overcharge to the Public Welfare Division by Emanuel Hospital. Mr. Fawkes testified:

"Q (By Mr. VavRosky) Mr. Fawkes, with respect to Paragraph V and Paragraph VI, Mr. Hartman has alluded to the Pharmaceutical Services Guide for Public Welfare Medical Assistance Programs.

"I think that has been made an exhibit in this deposition.

"With respect to Paragraph VIII Mr. Hartman explained a situation involving a charge for a drug to the Welfare Division.

"Have you had occasion to check on the accuracy of that statement?

"A Yes, I looked this prescription up and it was for a woman who is a Welfare patient and also a member of our resident outpatient clinic and the price he has on there is correct, that is what this patient was charged or the charge that was put on the prescription for this patient.

* * *

"Q (By Mr. VavRosky) As to Prescription No. 468-522B, line 20, Mr. Fawkes, have you had occasion to check on the charges as related by that prescription?

"A Yes, *this was incorrectly charged.* It should have been $3.85 on there and how it was charged wrong I can't tell you, unless they took it from the line above or the line below on the schedule, but it was a mistake. It went through and they didn't catch it down there." (Fawkes Dec. 21, 1972 deposition, p. 32, lines 14-25; p. 33, lines 1-4; 11-18) (emphasis added)

The record is full of testimony and exhibits confirming that the alleged "nonprofit" hospitals sell drugs to employees and physicians for substantially less than the general price. Employees and physicians are within the definition of the term "General Public."

[R. 551]

Exhibit C is State Public Welfare Division form PWD 502, revised 8/72, titled "PRESCRIPTION DRUG INVOICE." Hospitals and others that bill the state for prescriptions are required to use the form, which contains a certification that the drugs or services were rendered according to Oregon law and the rules and regulations of the Public Welfare Division.

At the bottom of the form is the following order in large, red block letters:

> "YOU MUST BILL AT YOUR CHARGE TO THE 'GENERAL PUBLIC' IF LESS THAN THE AMOUNT ALLOWED BY WELFARE."

Emanuel Hospital's employees and physicians constitute a "General Public" within the meaning of the agency's regulations. Employees and physicians of the hospital receive their prescription drugs for less than the maximum welfare rate. However, plaintiff's deposition discovery established that Emanuel Hospital bills the state at the welfare level or above, instead of the much lower rate granted employees and physicians.

25. The record establishes that the alleged "non-

profit" hospitals, especially Kaiser, are capturing more of the retail drug business in the Portland area year after year. The figures in the record are obsolete because the new figures accumulated and reflecting growth since the end of plaintiff's limited depositions are not in the record. What is in the record, however, is a realistic projection of drug sales in competition with community pharmacies by 1980 — seven years from now. The projection is found in Greenlick Kaiser deposition exhibit no. 3-215:

> "The Long Range Planning Committee has projected that by 1980, the Kaiser medical care system should consist of two hospitals and eight clinic pharmacies, two of which will be physically integrated within the hospitals.
>
> (no paragraph)

[R. 552]

> Projecting the estimated outpatient prescription workload upon the future number of facilities indicates *an average daily workload of approximately 600 outpatient prescriptions per pharmacy.*
>
> (no paragraph)
>
> In addition, rough estimates of future physician distribution patterns among clinics indicates that *the projected workloads may approach 1000 outpatient prescriptions per day in certain clinic pharmacies.* * * *" (emphasis supplied)

Greenlick Kaiser deposition exhibit no. 4-86 estimates that by 1980 Kaiser pharmacies in the Port-

land area will be filling *779,100 prescriptions a year*, and Kaiser is but one of a group of alleged "non-profit" hospitals engaged in retail drug sales in this area.

The second Kaiser hospital referred to in Greenlick exhibit no. 3-215 is under construction, as reported in the November 28, 1972 *Oregon Journal* under the headline of $6.8 Million Hospital Goes to Minden Const.":

> "The board of directors of Kaiser Foundation Hospitals Tuesday awarded a contract in excess of $6.8 million to the Minden Construction Co. of Portland for construction of a medical center on Sunnyside Road, North Clackamas County.
>
> "The site is a 29-acre parcel east of Stevens Road, 1,000 feet from the proposed I-205 Sunnyside Road interchange.
>
> "Phase 1 will be a 131-bed general hospital and a 24 physician out-patient clinic including the usual auxiliary services. * * *"

26. The Court has forbidden plaintiff to make discovery concerning the preferential prices, terms and conditions the defendants grant to the alleged "non-profit" hospitals, but not to plaintiff's assignors and other community pharmacies. However, Greenlick deposition exhibit no. 3-96—table 18—contains Kaiser drug acquisition costs for 1968 and 1969 that are subject to measurement against the average prescription acquisition cost reported by defendant Eli Lilly and Company in its

nationally recognized publication, the *Lilly Digest*.

For 1968 the Kaiser acquisition cost was $1.67 per prescription and the *Lilly Digest* cost was $2.25.

For 1969 the Kaiser acquisition cost was $1.48 per prescription and the *Lilly Digest* cost was $2.34.

For 1968, therefore, Kaiser had a 25.8 percent lower drug acquisition cost than the pharmacies whose costs were reported in the *Lilly Digest*.

For 1969 Kaiser had a 36.7 percent lower drug acquisition cost than the pharmacies whose costs were reported in the *Lilly Digest*.

The preferential prices Kaiser receives from the defendants and other drug manufacturers enable Kaiser to compete successfully with plaintiff's assignors and other community pharmacies for the retail drug trade in Multnomah, Clackamas and Washington counties,

* * * * *

(Subscription, jurat and certificate of service omitted in printing)

[R. 555]

United States District Court for the District of Oregon

PLAINTIFF'S RULE 56 AFFIDAVIT RE AUDIT DOCUMENTS OF ALLEGED "NONPROFIT" HOSPITALS

(Filed April 3, 1973; caption omitted in printing)

STATE OF OREGON)
) ss.
County of Multnomah)

I, HENRY KANE, being first duly sworn, depose and say:

1. I am one of the attorneys for plaintiff, am familiar with the records of this case, conducted all of plaintiff's depositions concerning what defendants term the "threshold" issue of drug distribution practices of alleged "nonprofit" hospitals, cross-examined the three witnesses whose depositions were taken by defendants on said issue, have studied the series of documents produced by the various hospital witnesses pursuant to subpoena duces tecum, and am qualified to make this affidavit in opposition to defendants' motion for summary judgment on plaintiff's Second Cause of Action.

2. The subpoena duces tecum served on various witnesses deposed by plaintiff required said witnesses to produce documents pertaining to the hospital's pharmacy operation. Some witnesses were most cooperative in producing documents pursuant to subpoena while others were less than

[R. 556]

fully cooperative. The documents attached to this exhibit contain evidence the plaintiff was unable to obtain from various of the hospital witnesses deposed by plaintiff.

3. The Health Division of the Oregon State Department of Human Resources has in its possession as public records in its Portland office, State Office Building, Portland, Oregon 97201, audit reports and financial statements and letters of transmittal submitted to the Division by various hospitals, including alleged "nonprofit" hospitals whose officials and employees were deposed by plaintiff.

4. On April 2, 1973, Mr. Cornelius C. Bateson, Administrator of the Health Division of the Oregon State Department of Human Resources and custodian of its records, personally granted your affiant permission to examine and copy said documents as public records.

5. On April 2 and 3, 1973, your affiant personally inspected said public records and copied certain of them, which are attached to this affidavit as exhibits to said affidavit.

6. I certify that the documents attached to this affidavit are in context, are true, full and correct copies of the originals in the possession of Mr. Bateson, and contain evidence relevant and material to defendants' motion for summary judgment on plaintiff's Second Cause of Action. As an example, an Emanuel Hospital document reflects "nonpatient" op-

erating revenue for pharmacy of $47,921 in 1969 and $53,129 in 1970. A Willamette Falls Community Hospital document for the year ended July 31, 1971, reflects pharmacy department operating expenses of $114,049. That document permits calculation of net income. However, Errol Hollowell, Administrator of said hospital, said at page 10 of his deposition that he did not have documents called for by his subpoena duces tecum pertaining to net income from pharmacy drug sales. All he produced were documents pertaining to gross income and said he could not estimate—only guess—at net income. Obviously, an expense figure for pharmacy should permit an administrator to make an estimate of net income after deducting expenses from gross income.

[R. 557]

7. The exhibits to this affidavit reflect the fact that the hospital auditors and accountants found that the hospitals earned substantial net income as follows:

Emanuel Hospital:		
	1971	$ 568,550
	1970	411,259
	1969	436,135
Good Samaritan Hospital:		
	1971	717,112
	1970	1,037,480
Holladay Park Hospital:		
	1971	386,480
	1970	383,065
Portland Adventist Hospital:		
	1970	304,907

Portland Osteopathic Hospital:		
	1970	201,497
	1969	38,176
Providence Hospital:		
	1970	909,739
Tuality Community Hospital:		
	1971	160,579.68
	1970	218,454.55
St. Vincent Hospital:		
	1970	1,200,538
Willamette Falls Community Hospital:		
	1971	175,034

8. The above figures cover varying periods and do not reflect the net income of all 14 alleged "non-profit" hospitals. However, two hospitals reported net incomes in excess of $1 million per year and the total of the above-listed figures is *$7,149,005*. The above figures are those computed by the accountants and auditors and while each used various methods of arriving at the figures, my analysis of the reports indicate they are accurate and reflect hospital net profits.

(Subscription, jurat and certificate of service omitted in printing)

[R. 605]

United States District Court for the District of Oregon

PLAINTIFF'S OBJECTION TO "USE" OR "DESTINATION" TESTIMONY RE DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON SECOND CAUSE OF ACTION, AND BRIEF IN SUPPORT OF OBJECTION

(Filed April 6, 1973; caption omitted in printing)

Without waiving prior objections and pursuant to prior orders of the Court and the Federal Rules of Civil Procedure, plaintiff objects to all deposition testimony and exhibits pertaining in whole or in part to "use" or "destination" of profits from drug sales by the 14 alleged "nonprofit" hospitals, on the ground and for the reason that they are irrelevant and immaterial to the issues raised by plaintiff's Second Cause of Action and defendants' motion for summary judgment on the Second Cause of Action.

DATED: April 5, 1973.

(Subscription omitted in printing)

[R. 606]

BRIEF IN SUPPORT OF MOTION

At issue is whether 14 alleged "nonprofit" hospitals in the Portland area are selling drugs to the public outside of the "for their own use" exemption from the Robinson-Patman Act granted by 15 U.S.C. § 13c.

Two of the 14 hospitals, Kaiser and Willamette Methodist, file federal income tax returns and pay federal income taxes on substantial portions of their

drug sales unrelated to their hospital function. (Scott Kaiser deposition of October 20, 1972, pp. 31-35; Phelan Kaiser deposition; Scott Kaiser deposition exhibit no. 27; Slick Willamette Methodist deposition exhibits numbers 6, 6A, 6B, 6C, 6D and 6E.)

The evidence is uncontradicted that the alleged "nonprofit" hospitals sell drugs to nonhospitalized persons and in the process make huge profits both in dollars and in profit percentages on their drug sales.

Because of the overwhelming evidence of commercial business outside of the 15 U.S.C. § 13c exemption, the defendants at page 7 of their memorandum the startling contradiction of alleged "nonprofit" hospitals earning millions of dollars from their patients and members of the public [sic].

Defendants attempt to do so by misplaced reliance on "use" or "destination" of the drug profits.

Whatever may have been the earlier case law on the subject, the present applicable case law and controlling statutes make irrelevant and immaterial the "use" or "destination" of the profits.

If "use" or "destination" were relevant, there would be no necessity for Kaiser, for example, on advice of counsel, to pay substantial federal income taxes since 1968 on its unrelated drug sales.

The Ninth Circuit and general rule, reinforced by the loophole closing amendments of the Tax Reform Act of 1969, P. L. 91-172, make the *source* of the profits, not the "use" or "destination" controlling.

The source is controlling because of public policy considerations.

[R. 607]

Exhibit A to this brief consists of portions of "TAX-EXEMPT FOUNDATIONS AND CHARITABLE TRUSTS: THEIR IMPACT ON OUR ECONOMY," the Chairman's Report to the Select Committee on Small Business, House of Representatives, 87th Congress, December 31, 1962.

The author is the Honorable Wright Patman, Chairman of the House Select Committee on Small Business and co-author of the Robinson-Patman Act.

Exhibit A is submitted to reflect some of the findings of abuse of their exemption by tax-exempt organizations that culminated in adoption of the Tax Reform Act of 1969. See, for example, the effects of the amendments on:

15 U.S.C. § 511, imposition of tax on unrelated income of charitable, etc., organizations;

15 U.S.C. § 512, unrelated business taxable income;

15 U.S.C. § 513, unrelated trade or business;

15 U.S.C. § 514, unrelated debt-financed income.

2 *U.S. Cong. & Adm. News*, 1969, pp. 2033-34, quoted the Senate report:

> "2. *Tax-exempt Organizations Generally* — Under both versions of the bill, unrelated activities of tax-exempt organizations are restricted. * * * Second, *the unrelated business income tax is extended to virtually all tax-exempt organizations not previously covered*, including churches (after 1975). * * * (emphasis supplied)

1 *Federal Tax Regulations*, 1972, pp. 1369-70, § 1.513-1, Definition of unrelated trade or business, states in part:

> "(b) *Trade or business.* The primary objective of adoption of the unrelated business income tax was to eliminate a source of unfair competition by placing the unrelated business activities of certain exempt organizations upon the same basis as the non-exempt business endeavors with which they compete. In general, any activity of a section 511 organization which is carried on for the production of income and which otherwise possesses the characteristics required to constitute 'trade or business' within the meaning of section 162—

[R. 608]

> and which, in addition, is not substantially related to the performance of exempt functions—presents sufficient likelihood of unfair competition to be within the policy of the tax.
>
> (no paragraph)
>
> Accordingly, for the purposes of section 513 the term 'trade or business' has the same meaning it has in section 162, and generally includes any activity carried on for the production of income from the sale of goods or performance of services.
>
> * * *
>
> Activities of producing or distributing goods or performing services from which a particular

amount of gross income is derived do not lose identity as trade or business merely because they are carried on within a larger aggregate of similar activities or within a larger complex of other endeavors which may, or may not, be related to the exempt purposes of the organization.

(no paragraph)

Thus, for example, *the regular sale of pharmaceutical supplies to the general public by a hospital pharmacy does not lose identity as trade or business merely because the pharmacy also furnishes supplies to the hospital and patients of the hospital in accordance with its exempt purposes* or in compliance with the terms of section 513(a)(2). * * *" (emphasis supplied)

At this point it should be noted that under Oregon law the 14 alleged "nonprofit" hospitals could perform drug distribution activities within the hospital to their patients *without* a pharmacy.

ORS 689.170, relating to the application of ORS Chapter 689 (pharmacy) to hospital pharmacies and drug rooms, provides that a hospital may operate with the "drug room" under the supervision of a consulting pharmacist:

"(1) In a hospital having a pharmacy and employing a pharmacist, the pharmacy and pharmacist are subject to the requirements of this chapter. A hospital which does not have a pharmacy must have a drug room. In a hospital having a drug room as may be authorized by rule of the State Board of Health, *the drug room is not subject to the requirements of this chapter relating to pharmacies.* However, a drug room must be supervised by a consulting pharmacist. * * *" (emphasis supplied)

[R. 609]

A hospital drug room under ORS 689.170 dispenses drug orders to inpatients without a prescription because a physician's hospital order is sufficient.

However, the 14 alleged "nonprofit" hospitals operate licensed pharmacies, not ORS 689.170 drug rooms. A major reason is that these hospitals sell prescriptions to persons not hospitalized inpatients, hence the prescriptions must be issued by a pharmacist.

The Ninth Circuit in a recent opinion restated its opposition to the "destination" theory of tax exemption: *University Hill Foundation* v. *C.I.R.*, 446 F2d 701 (9th Cir. 1971), cert. den., 405 U.S. 965. In reversing the tax court the Ninth Circuit held that the foundation, which paid its profits to tax-exempt university and which was engaged in business, was *not* entitled to tax exemption.

The Ninth Circuit said at 446 F2d 704:

"* * * This court has consistently adhered to this second, source-of-income approach. * * * Underlying this approach is the judgment that section 101(6) was intended by Congress 'to tax all business income, however destined, unless the company was really not in business at all.' * * *"

The Court noted at 446 F2d 706:

"* * * Several courts of appeals, including this

court, have considered section 101(6) as thus amended in the light of its legislative history. Without exception, they concluded that in amending section 101 the Congress intended to require courts to adopt the source-of-income test previously followed by this circuit, rather than the destination-of-income test that had been followed in other circuits. * * *"

University Hill Foundation dealt with a so-called "feeder" organization, but the rationale applies, it is submitted, to all trade and business activities of tax-exempt groups under the Tax Reform Act of 1969 and the relevant Internal Revenue Service regulations.

Also see *Bear Gulch Water Co.* v. *C.I.R.*, 116 F2d 975 (9th Cir. 1941) which denied tax exemption to a water corporation entirely owned by the Regents of the University of California.

[R. 610]

People's Educational Camp Society, Inc. v. *C.I.R.*, 331 F2d 923 (2d Cir. 1964) held that the "destination of income" test did not afford income tax exemption to a public welfare corporation which used much of its revenue to improve its ability to compete commercially.

The Second Circuit said of the law adopted in 1950 to close tax-exemption loopholes:

"* * * Moreover, the Congressional purpose behind the 1950 enactment of both the feeder provision now in Section 502 and the unrelated business income amendment now in Section 511 was to prevent organizations with tax exempt status from competing unfairly with ordinary, taxed business entities. * * * we think that the Congressional purpose behind both it and the feeder provision instructs us not to apply the destination test broadly but to deny exempt status to petitioner, an entity which has directed so much of its revenue toward improving its ability to compete as a commercial operation through the accumulation of large surpluses and the expansion of its income producing facilities."

In this connection there is ample evidence in the record, e.g., Scott Kaiser deposition exhibit no. 11, and the constant expansion of Kaiser facilities in the Portland area, that the various alleged "nonprofit" hospitals have used their profits to expand their income-producing facilities.

The 14 alleged "nonprofit" hospitals compete with plaintiff's assignors and other *taxed* community pharmacies. They also compete with *taxed* proprietary hospitals with which they are in competition.

The Second Circuit carefully distinguished a case relied on by defendants, *Debs Memorial Radio Fund* v. *C.I.R.*, 148 F2d 948 (2d Cir. 1945):

"* * * No sizable surpluses were accumulated; in fact, the court noted that up to the end of the period under review the station's operating expenses had exceeded its operating receipts by some $37,000." (148 F2d at 935, fn 14)

[R. 611]

The radio station in *Debs Memorial Radio Fund* operated at a loss before it began selling some commercial advertising time and still operated at a loss after such sales.

In contrast, the alleged "nonprofit" hospitals earn substantial profits and have substantial net worth in excess of all liabilities. See PLAINTIFF'S RULE 56 AFFIDAVIT RE AUDIT DOCUMENTS OF ALLEGED "NONPROFIT" HOSPITALS, executed April 3, 1973.

Also see Exhibit B to this brief, the page from the Emanuel Hospital financial statement listing *"Investment in nonprofit corporations"*:

"The Hospital is a participant in three nonprofit corporations: Metropolitan Hospitals, Inc., Hospital Systems Center and Portland Hospital Service Corporation. The investments in these nonprofit corporations at December 31, 1971 are as follows:

Metropolitan Hospitals, Inc.	$327,263
Hospital Systems Center	12,241
Portland Hospital Service Corporation	9,000
	$348,504

"Metropolitan Hospitals, Inc., was formed by Emanuel and Physicians and Surgeons hospitals to own and operate Gresham Community Hospital and to construct and operate Meridian Park

Hospital. The initial expenses relating to planning and the construction period of the Meridian Park Hospital project are being shared by the two sponsoring hospitals on a fifty-fifty basis. At December 31, 1971, Emanuel Hospital had contributed *$327,263* as its share of these costs.

"The two sponsoring hospitals have also agreed to underwrite any operating deficits during the first three years of Meridian Park Hospital's operation. The estimated cost of the Hospital building and equipment is *$6,500,000*.

* * *

"Portland Hospital Service Corporation was incorporated to operate a joint laundry and linen service to initially serve five Metropolitan Portland hospitals. The estimated cost of the building, equipment and inventory, is *$2,175,000*." (emphasis supplied)

[R. 612]

Exhibit B was quoted, with the dollar amounts underlined, to emphasize that Emanuel and the other alleged "nonprofit" hospitals are Big Business operations engaged in Big Business transactions in competition with the remaining *tax-paying* proprietary hospitals.

Exhibit B refers to purchase of Gresham Community Hospital, but neglects to disclose that Gresham was a tax-paying proprietary hospital prior to its purchase. Gresham Community Hospital has been removed from the Multnomah County tax rolls

and to that extent the purchase with funds generated by tax-free operations has shifted the property tax load to other taxpayers.

Emanuel and other alleged "nonprofit" hospitals use profits generated from their tax-exempt activities to finance commercial-type operations, e.g., Emanuel Hospital's Portland Hospital Service Corporation competes with commercial laundries for laundry business.

Instructive, therefore, is *Louis W. and Maud Hill Family Foundation* v. *United States*, 347 F. Supp. 1225, 1227 (Minn. 1972):

> "The legislative history of §§ 511, 512 and 513 reflects that in enacting these statutes the Congress was attempting to eliminate a source of unfair business competition by placing the unrelated business activities of exempt organizations upon the same tax basis as non-exempt business endeavors with which they competed. Treas. Reg. § 513-1(b).
>
> (no paragraph)
>
> Hearings on the Revenue Act of 1950 revealed that exempt organizations were using their tax-exempt status to purchase ordinary businesses and to pay for them in installments out of subsequent tax exempt earnings, and were expanding existing business operations with tax free profits.
>
> * * *
>
> (no paragraph)
>
> With the enactment of §§ 511, 512 and 513, *charity-owned or charity-operated businesses were*

> *placed on the same tax basis as any active business notwithstanding the income derived therefrom was used for charitable purposes.*" (emphasis supplied)

In other words, "use" or "destination" is irrelevant!

[R. 613]

Before turning to the Oregon and other state cases relevant to the instant objection, plaintiff emphasizes that tax exemption of the 14 alleged "nonprofit" hospitals is *not* before this Court.

What the hospitals do or do not do with their profits from drug sales is irrelevant in this case and in this context.

The reason is that federal law permits a tax-exempt organization to engage in some commercial activity without necessarily losing its tax exemption. At the same time, however, federal law provides that a tax-exempt organization must pay federal income taxes on the profits from the organization's commercial activity. That is why Kaiser pays federal income taxes on its unrelated drug sales.

The latest reported Oregon decision on the subject of the instant objection appears to be *Umatilla County* v. *Sturtevant-City of Pendleton*, — Or —, 94 Adv Sh 749, 495 P2d 287 (March 23, 1972), which affirmed denial of tax exemption on "airport" property used by the city.

In rejecting the city's argument that exemption should be granted because rental income from the property was used to operate the city airport, the Court of Appeals held at 94 Adv Sh 751, 495 P2d 288:

> "Moreover, this argument necessarily embraces a theory of taxation long since rejected by our Supreme Court—that is, the 'destination of income' theory. Simply stated, this theory holds it is the destination of income, not the source thereof which eventually determines the right to exemption. In Bd. Pub., Meth. Church v. State Tax Com., 239 Or. 65, 396 P.2d 212 (1956), the court's opinion reviewed Oregon cases dating back to 1895 which hold that the proper determinant of the right to tax exemption in Oregon law is the *source* of income." (fn omitted) (Emphasis by Court).

Board of Publications of the Methodist Church v. *State Tax Commission*, 239 Or 65, 396 P2d 212 (1964), the Supreme Court held that a nonprofit, church-affiliated corporation which published and sold church publications and other books and magazines, maintained a store like any other commercial book store, and sold other merchandise to the public,

[R. 614]

was not entitled to exemption from corporation excise taxes, although profits were paid to the church.

The Supreme Court held at 239 Or 67:

> "For our purposes we think it is immaterial to what extent its sales may be related to church

> activity or in the furtherance of particular religious beliefs. All of plaintiff's business is for profit. It is commercial. It is of little consequence whether it sells Bibles for a profit or whether it sells pianos or tractors. It is in business to profit. *It is in direct competition with other privately owned publishers and retail stores doing a similar business.*" (emphasis supplied)

The Supreme Court said at 239 Or 69:

> "* * * The competitive, commercial nature of its business precludes exemption to plaintiff."

We find at 239 Or 73:

> "We think it also persuasive that in the only similar state court cases we can find or that have been cited, both almost identical to the instant case, the state courts have considered and refused to follow the federal cases that adopt the destination of income as the test. * * *"

Since the *Board of Publications* decision the federal decisions that adhere to the destination theory of exemption have been rendered irrelevant by the 1969 amendments to the Internal Revenue Code. But in any event, as the Supreme Court noted at 239 Or 70, "* * * the federal rule was not firmly established but was in conflict."

Sutter Hospital of Sacramento v. *City of Sacramento*, 244 P2d 390 (Cal. Sup. Ct. 1952) affirmed the tax liability of an alleged "nonprofit" hospital.

The California Supreme Court said at 244 P2d 393:

"* * * the test indicated by such phrases, as so construed, is not necessarily whether there is or may be a profit but whether the claimant is operated or conducted for the purpose of making a profit; that is,

[R. 615]

whether the charges are fixed with the intention of yielding a surplus over and above operating expenses: * * *"

In the case at bar the evidence is overwhelming that the alleged "nonprofit" hospitals fix their charges for drugs and other services to yield a substantial surplus over and above operating expenses. See PLAINTIFF'S RULE 56 AFFIDAVIT RE AUDIT DOCUMENTS OF ALLEGED "NONPROFIT" HOSPITALS, executed April 3, 1973. For 1970, Good Samaritan Hospital reported net income or profit of $1,037,480 and St. Vincent Hospital reported net income or profit of $1,200,538!

The California Supreme Court distinguished an earlier case in which there was no profit motive and expenses exceeded total revenue:

"* * * The question here involved was not presented there, and we did not intend to imply that property which was designedly and consistently operated for profit, even though the profit was used for exempt (hospital) purposes and not for the purpose of benefiting any individual, would be exempt. * * *" (294 P2d at 394)

The California Supreme Court then held at 294 P2d at 394:

"Here the determinative factor is the operation of plaintiff's property for the admitted purpose of producing a profit in the sense that the operation was one deliberately designed to produce income in excess of all operating costs. The fact that plaintiff has succeeded in producing net earnings is not accidental or allocable to a fortuitous error in judgment in determining the charges made for its services. On the contrary, plaintiff functioned on a sound financial basis in a manner akin to any modern commercial enterprise intent upon producing a profit from its operations. It is argued that the above-indicated construction of the welfare exemption, denying exemption because of the adoption of sound financial practices, will make it difficult, if not impossible, for modern hospitals to plan for expansion and the improvement of facilities for the better service of the public without losing the benefit of the exemption. This argument * * * should be addressed to the Legislature * * *."

[R. 616]

Cleveland Osteopathic Hospital v. *Zangerle*, 91 NW2d 261 (Ohio 1950) affirmed denial of tax exemption to an alleged "nonprofit" hospital that in 1948 made a profit of $111,007 on receipts of $485,532.

The Ohio Supreme Court held at 91 NW2d at 264:

"But where a hospital extends its facilities and services very largely to those who are able to and do pay the established rates for their accom-

modation and *designedly makes a very substantial profit* in so doing, it places itself in the classification of a business enterprise amenable to taxation, notwithstanding that some unfortunate persons without means are cared for free of charge. See 51 American Jurisprudence 607, Section 635. (Emphasis by Court)

* * *

"The bare fact that a hospital devotes the profits it makes from the conduct of its affairs to paying off indebtedness and to improving and enlarging its plant does not of itself place it in the category of a tax exempt charitable institution. *It is the use of the property and not the use of the proceeds derived therefrom which is determinative of the question of tax exemption.* * * *" (emphasis supplied)

—

Oklahoma Tax Commission v. *Sisters of the Sorrowful Mother*, 97 P2d 888 (Okla. 1940) held that the hospital was subject to a state excise tax because it was in competition with other hospitals:

The Oklahoma Supreme Court held at 97 P2d at 893:

> "* * * Full pay patients alone constituted about 56 per cent of the total number of patients. From these patients and those who paid less than full rates, the hospital derived an income considerably more than the total operating expense including the expense incurred by reason of the charity patients and those who paid less than the cost of service. To the extent of the 3,140 patients who paid full rates, plaintiff was clearly

> in competition with the four other hospitals engaged in the same business in the City of Tulsa."

Also see the tax denial case of *Rogers Memorial Sanitarium* v. *Town of Summit*, 279 NW 623 (Wisc.) 1938).

[R. 617]

THE KAISER SITUATION

Defendants' memorandum at page 3 concedes that Bess Kaiser Hospital is a membership as distinct from a fee-for-service hospital.

> "Two types of institutions are involved. The first, which includes 13 of the 14 institutions which plaintiff has investigated, provides inpatient and outpatient services on a fee-for-service basis to patients who are random members of the community, that is, individuals who are not members of a pre-determined group.
>
> (no paragraph)
>
> The second type provides under the Kaiser Permanente Health Care Program (Kaiser) comprehensive inpatient and outpatient services on a prepaid basis, primarily to members who have previously elected to obtain all or most of their health care needs from the Kaiser program." (Def. mem. 3, lines 20-29)

Defendants also state:

> "As described above, Kaiser's members contract with Health Plan for medical services on a prepaid basis. In turn, Health Plan contracts with Hospitals, The Permanente Clinic and PSO to

deliver those services to members (Scott Dep. I, 37)." (Def. mem. 19, lines 28-31)

The mere fact that Health Plan is an alleged "non-profit" corporation is irrelevant. Health Plan, according to plaintiff's investigation, does *not* have a state or federal tax exemption. At the state level, plaintiff has been informed, any contribution to Health Plan would *not* be tax deductible.

Kaiser Health Plan of Oregon is a membership organization, as is Oregon Physicians' Service.

Oregon Physicians' Service v. *State Tax Commission*, 220 Or 487, 349 P2d 831 (1960) held that OPS was subject to taxation.

The Oregon Supreme Court noted at 220 Or at 493:

"Not uncommonly, charitable and other non-profit associations compete actively with private business. To the extent that a charitable corporation is relieved of the tax burden it gains a competitive advantage. To the extent that such tax

[R. 618]

tax relief is not based on reasonable classification for sound public ends it is a denial of equal protection of its laws. Strict construction of exemption statutes thus with us has constitutional overtones. * * *"

The Court also noted at 220 Or at 499:

"* * * Oregon Physicians' Service, on the oth-

er hand, entered a field already occupied by privately operated insurance companies, though there may have been features of the private plans to which physicians could properly take exception."

The Court held at 220 Or at 506-07:

"* * * If the 'dominant and controlling' motive of the taxpayer is 'primarily to benefit the taxpayer's membership economically, and only incidentally to further larger public welfare,' then the exemption must be denied. * * * The group benefited may be large or small, definite or indefinite in number, but in the benefaction some motive of altruism must clearly shine forth.

"That is not the case here. Oregon Physicians' Service is a medical insurance company, and its members can have no motive beyond insuring themselves against the expense of illness. Commendable as that may be, it is a self-regarding purpose. The company is carried on for no other reason. Even if the plaintiff devoted its entire income above expenses to charity, we would be obliged to deny the exemption.

(no paragraph)

For while it is now clearly established that a charity may carry on some commercial business without losing its exemption * * * we think it is equally clear that *an organization which obviously exists only for the benefit of its members can not claim exemption from taxation even though it pays no dividends or devotes its entire profits to charity.* * * *" (emphasis supplied)

The above-quoted *OPS* decision relies on and cites numerous federal decisions relevant to the membership issue.

[R. 619]

Friendsview Manor v. *State Tax Commission*, 247 Or 94, 104, 420 P2d 77, 427 P2d 417 (1967) noted:

> "In *La Societe Francaise, etc.* v. *California Employ. Com.*, 56 Cal App2d 534, 133 P2d 47, cert den 320 US 736, 64 S Ct 35, 88 L ed 426 (1943) the court made the distinction between providing hospital care for others and for one's self. Members of La Societe paid an admission fee and monthly dues into La Societe. If they became ill they received gratis from La Societe medical and hospital benefits. No profit was made; it was an agency of the Community Chest. Nevertheless, the court held it was not a charitable corporation and thus not exempt from the payment of California Unemployment Insurance taxes. The crux of the court's decision was as follows:
>
> > '* * * *The true rule is that when people band together to purchase hospital care in the event of illness, it is a business venture rather than a charitable undertaking, and the beneficiaries thereof do not consider the benefits received to be "charity."* * * *.' (Emphasis added.) 56 Cal App2d at 545-546.
>
> "Similarly, the English courts have found an organization formed by its members to provide hospital care to its members to be noncharitable. Salmon, J., stated: 'Moreover, the object of the members of the society is not to do good to others

[R. 620]

The articles of incorporation of the various Kaiser organizations are, of course, not conclusive as to the "charitable" nature of these organizations.

Oregon Methodist Homes, Inc., Willamette View Manor, Inc. v. *State Tax Commission*, 226 Or. 298, 308, 360 P2d 293 (1961) held:

> "The question as to whether given hospital is a charity is to be determined in the case of an incorporated hospital not only from its powers as but to themselves. This object is not altruistic and is in my judgment not charitable.' *Waterson* v. *Hendon B. C.*, [1959] 2 All E R 760, 764 (QB)."

At this point plaintiff calls attention to the fact that Bess Kaiser Hospital is a "membership" organization affiliated, according to the record, with only one group of physicians, The Permanente Clinic. The Bess Kaiser Hospital, therefore differs from the so-called fee-for-service hospitals, to use defendants' designation, because it serves "members," not general members of the public who may need hospitalization.

Moreover, defendants do not claim that the Bess Kaiser Hospital is a "charitable" hospital or that it admits "charity" patients.

Plaintiff has searched the voluminous record pertaining to Kaiser, but cannot locate any testimony or exhibit that indicates, directly or indirectly, that Bess Kaiser Hospital is "charitable."

defined in its charter, but also from the manner in which it is conducted and such prima facie evidence as its articles may accord can be rebutted by evidence that the corporation has not in fact lived up to its chartered objects. * * *
(no paragraph)
This is a sound and salutory rule. It is one reflecting human experience. Unselfish declarations of intended purpose and promises of future worthy endeavor are many times rendered meaningless by inaction and should give the declarer no preferred status unless ultimately resolved into concrete and tangible reality."

The above principle was applied in denying tax exemption to a hospital service corporation in *United Hospitals Service Ass'n* v. *Fulton County*, 114 SE2d 524 (Ga. 1960).

The similarity between Kaiser Foundation Health Plan of Oregon and the United Hospitals Service Association is striking:

"The plaintiff's petition attaches a copy of the contract or insurance policy which it issues to its members. Not the public, not just the poor and needy, but those and only those whose application is approved by the petitioner are allowed to obtain the benefits covered by the policy.
(no paragraph)
This means that the petitioner has the right to accept applications from those well able to pay for hospital service and to reject the poor and needy. And every policy holder is required to pay premiums whether he requires service or not, and

once he has received the amount of services paid for,

[R. 621]

he must either leave the hospital before he is physically able or look elsewhere for charity to provide such needed services.
(no paragraph)
This brief recital of relevant facts demonstrates (1) that only such hospital services as are paid for are available; (2) such services are not available to the public, but confined entirely to the private individuals whose applications and money have been accepted; (3) the poor and needy may all be denied any such services; and (4) only the amount of service specified in the policy and paid for by the members is given, and after that this institution contributes nothing, and charity, either private or public is the only hope for additionally needed hospital service for those who are unable to pay."

The above-quoted characterization of the health plan is equally applicable to the contractual health service provided, or not provided, by the Kaiser organizations pursuant to various levels of contractual service.

Greenlick Kaiser deposition exhibit no. 4-13 makes clear that the drugs distributed by Kaiser are designed for the membership, for there is no reference to charity patients:

"The drug system of Kaiser Foundation Hos-

pitals, Portland, Oregon, provides both prescription and over-the-counter drugs to the Health Plan membership, for both ambulatory patients (outpatients) and hospitalized patients (inpatients) upon written or verbal prescribing order by Permanente physicians. * * *"

The Kaiser pharmacies also sell drugs to the general public, as admitted by defendants at page 21 of their memorandum:

"As with the fee-for-service hospital pharmacies, the Kaiser pharmacies dispense drugs to nonmembers * * *." (Def. mem. 21, lines 19-20)

Also see:

Hassett v. *Associated Hospital Service Corporation of Massachusetts*, 125 F2d 611 (1942), cert. den. 316 US 672

[R. 622]

Evanston-North Shore Board of Realtors v. *United States*, 320 F2d 375 (Ct. Cl. 1963), cert. den. 376 US 931

Lincoln Memorial Hospital, Inc. v. *Warren*, 235 NE2d 129 (Ohio 1968)

Frisco Employes' Hospital Association v. *State Tax Commission*, 381 SW2d 772 (Mo. 1964)

The preceding four pages of this brief were devoted to the Kaiser situation to prove that the "use" or "destination" test is irrelevant to prescription drug purchases by Kaiser Foundation Health Plan members from Kaiser pharmacies.

Health Plan members have various prescription drug benefits that require or encourage them to purchase their prescription drugs from Kaiser pharmacies.

Greenlick Kaiser deposition exhibit no. 4-44 states:

"Prescription drug orders presented to Kaiser pharmacies by outpatients are priced according to type of Kaiser membership coverage and at a "reduced charge." [sic] Normally the charge must be paid by the patient at the time he receives the prescription. Similarly, non-prescription drugs are available to members at a reduced charge, payable upon receipt of the drug item. * * *"

Greenlick Kaiser deposition exhibit no. 4-45 states:

"As previously indicated, most Health Plan members pay for drug costs on an 'out-of-pocket' basis. However, certain Health Plan member groups through third party agencies have modified the method of payment and the resulting prescription pricing system. The third party agencies have negotiated with the Kaiser Health Plan to provide particular groups with prescriptions under a prepayment mechanism. * * * For example, the most common arrangement is for the member to pay a charge of one dollar for each prescription of a month's supply or less, and for the sponsoring third party agency to pay the balance through premiums. * * *"

In other words, there are various plans under which a member purchases his regular supply of drugs from the Kaiser pharmacies, without reference to whether or not he is an "inpatient" or an "outpatient."

[R. 623]

Additional evidence that the bulk of Health Plan prescriptions have no connection with hospital "outpatient" treatment is found in Greenlick Kaiser deposition exhibit no. 4-67 under the heading of "Redispensing":

> "* * * The request to renew a prescription order may be made by patient appearance or by telephone. If the request is made by patient appearance in the pharmacy the original prescription is retrieved from the prescription files. A determination is then made as to whether or not the prescription is renewable. If renewable, the prescription will enter the dispensing process. If no refills are indicated, the patient is directed to see a physician on duty in the appropriate outpatient clinic department. * * *
>
> "Prescription renewal requests are also commonly made by telephone. * * *"

The above description reflects the fact that refills are filled routinely without the necessity or red tape of the purchaser being an "outpatient" receiving "outpatient" care from the hospital. Indeed, only a fraction of refills are handled in the Kaiser Hospital pharmacy. The bulk of the refills are handled in the clinic pharmacies.

A large but undetermined portion of Kaiser drug purchases, therefore, are made by Health Plan members who are not ambulatory "outpatients" receiving hospital care on an "outpatient" basis.

Thus, in referring to prescriptions dispensed "per physicians' office visit," Greenlick Kaiser deposition exhibit no. 5 states:

> "During 1962 it was decided to reduce the cost of drugs for plan members by lowering the price of all *out-of-hospital* prescriptions written by plan physicians and dispensed in plan pharmacies. * * *" (emphasis supplied)

"Out-of-hospital" prescriptions is an accurate discription, [sic] for the term describes prescriptions issued to Health Plan members without a visit to the Kaiser hospital for "outpatient" care.

The key fact is that Kaiser is selling drugs to the equivalent of "walk-in" customers who are *not* connected with the hospital as a matter of law because Health Plan is *not* a "nonprofit" organization.

[R. 624]

Health Plan is a non-exempt commercial organization that sells prepaid health and drug benefits that are similar to those offered by competing companies, including Lincoln National Life Insurance Company. See Wiggin deposition p. 11.

Health Plan members have no connection with the Kaiser Hospital unless they are hospitalized "inpatients" or receive care as patients carried on the records as "inpatients," e.g., persons receiving treatment in the emergency room.

Otherwise, Health Plan members are members of

the general public when they purchase drugs at preferential prices from Kaiser.

Consequently, Kaiser's drug sales to Health Plan members who are not "inpatients" or "outpatients" are outside of the 15 U.S.C. § 13c exemption from the Robinson-Patman Act. And those sales are more than *de minimus*. [sic] Also see Wiggin deposition exhibit no. 3 et seq., some 2,000 Kaiser prescriptions processed by Lincoln National Life Insurance Company.

We turn now to the cases relied on by defendants concerning "use" or "destination" of profits from drug sales to the public.

Each of defendants' cases is distinguishable.

Defendants read too much into the quoted passage from *Logan Lanes, Inc.* v. *Brunswick Corporation*, 378 F2d 212, 216 (9th Cir. 1967), cert. den. 389 US 898. On its face *Logan Lanes* was decided prior to adoption of the Tax Reform Act of 1969.

All the Ninth Circuit said was that the fact was undisputed that all net income from the bowling alleys were [sic] used to finance student activity proprams or the expansion and improvement of the university.

The passage relied on by defendants is irrelevant, because the test for purposes of the instant motion has nothing to do with the use made of the profits. What is relevant is whether the bowling establishment operated by the university was in competition with the commercial bowling establishment operated by

plaintiff in *Logan Lanes*. The quoted passage was dicta, not a holding.

[R. 625]

Students Book Company v. *Washington Law Book Company*, 222 F2d 49, 50-51, fn. 5 (DCA 1955), cert. den. 350 US 988, held:

> "5. Appellee also argues that, even if its transactions with the campus book stores were sales, they were exempted from the application of the Robinson-Patman Act by virtue of 52 Stat. 446, 15 U.S.C. § 13c, which provides:
>
> 'Nothing in sections 13-13b * * * of this title shall apply to purchases of their supplies for their own use by schools, colleges, universities, and libraries, churches, hospitals, and charitable institutions not operated for profit.'
>
> Although the appellee has sold books to all three of the universities for their own use, *i.e.*, for their libraries, *the transactions here in question were not actually with the universities, but with the self-sustaining campus book stores, and the books sold were not for the use of the universities, but for resale at a profit. The exemption provision is therefore inapplicable to these transactions.*" (emphasis added)

In *Logan Lanes* the bowling equipment was purchased by the university for the use of the university.

In the case at bar the drug sales at issue involve purchases by the hospitals not for their own use within the 15 U.S.C. § 13c exemption, but for sales to the public.

In *Logan Lanes* the university would have purchased the bowling equipment whether or not it allowed members of the public to use its bowling facilities.

In the case at bar, it must be emphasized, the hospitals would *not* have purchased the drugs resold to the public if the drugs were not to be resold to the public. The hospitals purchased a large quantity of drugs, part of which was for resale to the public in competition with plaintiff's assignors and other community pharmacies. The drugs resold to the public outside of the exemption were separate from their drug purchases for their 15 U.S.C. § 13c "own use."

[R. 626]

Community Blood Bank v. *Federal Trade Commission*, 405 F2d 1011 (8th Cir. 1969) is irrelevant because the case merely decided that the Federal Trade Commission lacked jurisdiction.

The Eighth Circuit held at 405 F2d 1022:

"By way of summary, we hold:

"1. That under § 4 the Commission is vested with jurisdiction over nonprofit corporations without shares of capital, which are organized for and actually engaged in business for only

charitable purposes, and do not derive any 'profit' for themselves or their members within the meaning of the word 'profit' as attributed to corporations having shares of capital.

"3. That the corporate petitioners are true nonprofit corporations, not engaged in business for profit for themselves or their members.

"4. *That the Commission lacks jurisdiction over all of the petitioners.*" (emphasis supplied)

The holding was based on the conclusion that "Congress did not intend to bring within the reach of the Commission any and all nonprofit corporations regardless of their purposes and activities." (405 F2d 1018)

A blood bank may be exempt from the jurisdiction of the Federal Trade Commission, but its unrelated income is subject to taxation, according to Rev. Rul. 66-323, Cumulative Bulletin 66-2, Exhibit C to this brief.

The Ruling said at Cum. Bull. 66-2, p. 218:

"The selling of blood and blood components, such as raw serums, to commercial laboratories is business of a kind regularly carried on for profit. Such business is not substantially related to the purposes forming the basis for exemption of the organization. Accordingly, the *selling of blood and blood products to commercial laboratories constitutes the conduct of unrelated trade or business within the meaning of section 513 of the Code and the organization is subject to the tax imposed by section 511 of the Code.*" (emphasis supplied)

[R. 627]

The restricted view of the Federal Trade Commission's jurisdiction in *Community Blood Bank* v. *FTC*, supra, appears to have been eroded by *Federal Trade Commission* v. *Sperry & Hutchinson Co.*, 405 US 233 (1972).

After reviewing prior decisions that overruled earlier restricted interpretations of the Commission's jurisdiction, the Supreme Court held at 405 US 244:

> "Thus, legislative and judicial authorities alike convince us that the Federal Trade Commission does not arrogate excessive power to itself if, in measuring a practice against the elusive, but congressionally mandated standard of fairness, it, like a court of equity, considers public values beyond simply those enshrined in the letter or encompassed in the spirit of the antitrust laws." (fn omitted)

The Supreme Court then held at 405 US 245:

> "The general conclusion just enunciated requires us to hold that the Court of Appeals erred in its construction of § 5 of the Federal Trade Commission Act. * * *"

Defendants at page 9 of their memorandum impose on the Court when they raise and discuss an irrelevant rule of law: subject to statutory and case law requirements, a nonprofit corporation may use its profits for proper purposes. That rule has nothing to do with the instant motion or defendants' motion for summary judgment on plaintiff's Second Cause of Action.

CONCLUSION

Plaintiff's motion should be granted and the Court should reject as irrelevant and immaterial all deposition testimony and exhibits pertaining in whole or in part to "use" or "destination" of profits from drug sales by the 14 alleged 'nonprofit" hospitals.

* * * * *

(Subscription omitted in printing)

[R. 638]

EXHIBIT C TO PLAINTIFF'S OBJECTION TO "USE" OR "DESTINATION" TESTIMONY

* * * * *

(Also Sections 511, 513; 1.511-2, 1.513-1.)

Rev. Rul. 66-323

> A blood bank organized and operated exclusively for scientific and charitable purposes, to provide a community with permanent facilities for the collection and storage of human blood and blood products and to provide for the public distribution thereof, may be exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954.
>
> Income from the sale by the organization of blood and blood products to commercial laboratories constitutes income from an unrelated trade or business as defined in section 513 of the Code.

Advice has been requested whether a blood bank operated in the manner described below qualifies for

exemption from Federal income tax under section 501 (c)(3) of the Internal Revenue Code of 1954.

The organization was formed to establish and operate permanent facilities for the collection and distribution of human blood and blood products for the benefit of the public and to conduct related research. Its charter provides that no part of the organization's net earnings may inure to the benefit of any private shareholder or individual. In the event of dissolution, its assets are to be distributed to exempt charitable, scientific, or educational organizations to be used for exclusively exempt purposes.

The organization's board of trustees is comprised predominantly of public members who are not otherwise associated with it.

The blood bank was established to help meet the needs of a community. It obtains blood from professional and volunteer donors and supplies blood and blood products to hospitals, including local and Federal government institutions, doctors, clinics, and commercial laboratories. Within the limits of its ability, it supplies blood free for indigent and charity patients. The bank serves as a free repository of blood for a local research foundation in a volunteer program jointly maintained by it and the foundation. It also provides blood to other institutions for research purposes.

Other activities of the organization include (a) collaborating with an exempt organization in a free program of blood typing of volunteer donors; (b)

opening of several blood-drawing stations in the area which it serves; (c) pioneering in the development of a program to help meet the need for fresh blood in connection with the increasing use of open heart surgery as a standard surgical procedure; (d) allocating funds to a blood coagulation research program conducted jointly with an exempt research center; and (e) providing gratuitous services of an educational nature to the community. The organization also sells blood and blood components, such as raw serums, to commercial laboratories.

Although the organization charges those who are able to pay for its services, its charges for blood and blood products are generally less than the prevailing rates charged by commercial blood distributors. Furthermore, it is committed by its charter to use all funds received for its services in excess of operating costs for the accomplishment of its declared charitable purposes, including expansion of its services as required by the community need. Likewise, it is committed to furnish services to any person notwithstanding his inability to pay. Moreover, its trustees are required to review periodically the schedule of charges to insure that they are not higher than is reasonably necessary to enable it to perform its community function.

In carrying out its purposes, the bank has a volunteer blood replacement program which enables recipients of blood to extinguish, in whole or in part, the charges they would otherwise have to pay. With some

of the institutions it serves, replacement of blood is accepted on a two-for-one basis with no service charge. More usual, however, is full payment or replacement of blood on a one-for-one basis and payment of the service charge.

The blood bank's income is derived mainly from the sale of blood products and services to hospitals, doctors, clinics, and commercial laboratories. Its expenditures are for blood purchases, laboratory expenses, wages, administrative expenses, office supplies, delivery expenses, and other miscellaneous operating expenses.

Section 501(c)(3) of the Code provides for the exemption from Federal income tax of organizations organized and operated exclusively for charitable purposes.

[R. 639]

On the basis of the information set forth above, the organization serves a public purpose in a manner which qualifies it for exemption from Federal income tax as a charitable organization under section 501(c)(3) of the Code.

Section 511 of the Code imposes a tax on the unrelated business taxable income of organizations otherwise exempt from tax under section 501(c)(3) of the Code, with certain exceptions not pertinent here. Section 513 of the Code defines the term "unrelated trade or business" as any trade or business the conduct of which is not substantially related (aside from the need

of such organization for income or funds or the use it makes of the profits derived) to the exercise or performance by such organization of its exempt functions.

The selling of blood and blood components, such as raw serums, to commercial laboratories is business of a kind regularly carried on for profit. Such business is not substantially related to the purposes forming the basis for exemption of the organization. Accordingly, the selling of blood and blood products to commercial laboratories constitutes the conduct of unrelated trade or business within the meaning of section 513 of the Code, and the organization is subject to the tax imposed by section 511 of the Code.

An organization which considers itself within the scope of this Revenue Ruling must, in order to establish exemption under section 501(c)(3) of the Code, file an application on Form 1023, Exemption Application, with the District Director of Internal Revenue for the internal revenue district in which is located the principal place of busness or principal office of the organization. See section 1.501(a)-1 of the Income Tax Regulations.

* * * * *

(Certificate of service omitted in printing)

[R. 641]

United States District Court for the District of Oregon

RULE 56 AFFIDAVIT OF STANLEY E. HARTMAN IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION

(Filed April 10, 1973; caption omitted in printing)

STATE OF OREGON)
)ss.
County of Multnomah)

I, STANLEY E. HARTMAN, being first duly sworn, depose and say:

1. I am a registered pharmacist licensed by the State of Oregon, am engaged in the practice of pharmacy as a community pharmacist, am a member of the plaintiff, Portland Retail Druggists Association, Inc., am an officer of one of the assignors herein, have attended various of the drug practices depositions taken by plaintiff, have read and studied defendants' memorandum in support of their motion for summary judgment on the plaintiff's Second Cause of Action, and am competent to make this affidavit concerning the matters stated herein.

2. Pursuant to F.R.Civ.P. Rule 56(e), I make this affidavit in opposition to defendants' motion for partial summary judgment on the plaintiff's Second Cause of Action. It is based on personal knowledge.

3. Based on my knowledge of the practice of pharmacy and my familiarity with the practices of representatives of various of the

[R. 642]

defendants herein, I state that such representatives call at regular intervals on the alleged "nonprofit" hospital pharmacies, make observations concerning the drug practices of said pharmacies, submit oral and written reports of said observations to their superiors, and that said reports contain material evidence relevant to plaintiff's Second Cause of Action that would tend to support said cause of action. Such evidence is in the possession of defendants herein and should be the subject of discovery by plaintiff because it would contradict the disclaimers of various witnesses deposed by the parties concerning the sale or lack of sale of drugs to the general public by alleged "nonprofit" hospitals.

4. The alleged "nonprofit" hospitals are in direct competition with plaintiff's assignors and other community pharmacies, and such direct competition has been noted and acted upon by the Multnomah County Assessor. Exhibit A to this affidavit is Carson deposition exhibit numbers 3 and 3-1, an appraisal report on one of the alleged "nonprofit" hospitals, Gresham Community Hospital. Exhibit 3-1 states:

> "A pharmacy is located adjacent to the main entry. *Investigation revealed* that besides supplying the needs of hospital patients, *the public may make purchases from this pharmacy*. This may be a small volume of business but is in direct competition with taxpaying enterprises on the outside." (emphasis supplied)

Mr. Kermit Carson, Chief Office Deputy, Multnomah County Department of Taxation, testified:

"Q What is Deposition Exhibit 3 and 3-1?

"A This is our work sheet based upon our inspection of the Gresham General Hospital which was done in 1971-1972.

"Q The conclusion reached is that we have some private doctors offices, we have a pharmacy, we have an X-ray room and we have a laboratory in this hospital and the distinction here is that the X-ray room, laboratory room and so forth is accessible to private doctors whether they are using the hospital or not.

[R. 643]

"Q Was the fact that there is a pharmacy there a factor in making a portion of the hospital subject to assessment and taxation?

"A *Yes, it was.*

"Q Is that pharmacy accessible to the doctors in that facility?

"A *It is our understanding that it is, not only in the facility but to anyone in the community wishing to use it.*" (emphasis added) (Carson dep. pp. 8-9)

—

Carson deposition exhibit no. 3-1 reveals that the 343-square foot Gresham Community Hospital pharmacy is on the county tax roll.

Mr. Carson's deposition at pages 5 to 7 confirms that the Bess Kaiser Hospital pharmacy and other portions of the hospital are on the county tax roll.

Carson deposition exhibit no. 2 is a 1972 county field inspection report on the Bess Kaiser Hospital and states in part.

"* * * Areas considered to be not qualified, at the present time, are the Outpatient Clinic on the second floor, *the Pharmacy, which still fills prescriptions for patients from this clinic*, and access to these areas. * * * in re-investigation, it has been found that the areas now used in a non-qualifying manner accounts for 8% of the value of the improvements." (emphasis supplied) (EXHIBIT B)

The decision of the Multnomah County Assessor to tax the pharmacy facilities of Kaiser and Gresham Community hospitals is official recognition of the fact that the two hospitals compete with taxpaying community pharmacies for the retail trade in prescription drugs in Multnomah County.

5. St. Vincent Hospital fills a very sizeable [sic] number of prescriptions for use outside of the hospital. One particular group of patients not previously discussed consists of patients discharged from the hospital who are then immediately enrolled in an extended care facility. Quite frequently these are Medicare beneficiaries who are eligible for all drugs while hospital inpatients. These patients are also eligible for

[R. 644]

drugs in an extended care facility, but the number of days of eligibility for drugs is limited pursuant to a utilization review process. The West Hills Pharmacy, located at 5701 S. W. Multnomah Blvd., Portland, frequently receives filled prescriptions [sic] issued by St. Vincent Hospital to newly discharged patients entering the West Hills Convalescent Center, an extended care facility located at 5701 S. W. Multnomah Blvd., Portland.

There is much defensive-type deposition testimony concerning "take-home" prescriptions—prescriptions issued to inpatients for use following their discharge. The witnesses tend to testify that only a short-term supply of "take-home" drugs are issued, although they concede that they fill the prescription, regardless of the number of days of drug supply ordered.

On January 23, 1973, St. Vincent Hospital issued three prescriptions to a patient as "take-home" drugs for use following his discharge from St. Vincent.

(1) Prescription no. 167037 was for 100 valium 5 mg, a *25-day* supply;

(2) Prescription no. 167038 was for 100 Aldactizide tablets, a *50-day* supply;

(3) Prescription no. 167039 was for 100 dilatin 100 mgm, a *25-day* supply.

On the basis of the above prescriptions, the containers of which are in my personal possession, I state that St. Vincent Hospital sells "take-home" drugs for

use following discharge in excessive quantities and that these sales deprive community pharmacies of drug sales they would otherwise make in the usual and regular course of business. I further state that such "take-home" drug sales have no legitimate connection with the function of the St. Vincent Hospital and are not a convenience to patients so loaded with "take-home prescriptions. Patients are discharged during daylight hours. Following their daylight discharge they are able to purchase drugs from the pharmacy of their choice, directly or indirectly, and many community pharmacies make deliveries, including after-hour deliveries when so requested.

[R. 645]

Therefore "take-home" drug sales by the alleged "nonprofit" hospitals are *not* for the convenience of the discharged patients. They are sold as "take-home" drugs so that the drug charges can be added to the overall hospital bill and paid without question, to the greater profit of the "nonprofit" hospital.

6. On March 9, 1973, St. Vincent Hospital issued the following prescriptions as "take-home" drugs:

(1) Prescription no. 169060, ½ ampule NA Amytal 3¾gr ampule;

(2) Prescription no. 16902, Benadryl 50 mg 1cc.

7. Since St. Vincent Hospital prescriptions are numbered serially it is simple to computate [sic] the number of "take-home" and other prescriptions issued.

St. Vincent Hospital issued a total of 2,025 new "out patient" prescriptions between January 23, 1973 and March 9, 1973—a 45-day period. That figure, incidentally, is higher than the estimate of 1,000 per month given by Mr. Conrad M. McConnell, St. Vincent Hospital Director of Pharmacy. (McConnell dep. pp. 27-28) The average community pharmacy would be happy to fill 2,025 new prescriptions in a 45-day period. That number is not "de minimus!" [sic]

8. Various of the witnesses deposed by the plaintiff admitted that their "nonprofit" hospital pharmacies made prescription drug sales to "walk-in" members of the public and other customers who had no connection with the hospital, but tended to dismiss them as "emergency" sales.

Webster's Dictionary, Unabridged, Second Edition (1964), p. 593 defines "emergency" as follows:

> "a sudden or unexpected occurrence or combination of occurrences demanding prompt action; urgent necessity; * * *"

Most of the situations described by the witnesses are not emergencies. If they were, the person would receive emergncy room treatment as an outpatient. It is not an emergency that a community pharmacy may not be adjacent to the hospital, [sic] especially since many community pharmacies

[R. 646]

are open into the evening hours and their pharmacists will fill after-hour prescriptions. It is common for a community pharmacist to be called late at night to fill an emergency prescription, rush to his pharmacy to fill the prescription, and then personally deliver it to the person for whom the drug was prescribed.

On March 7, 1973, the plaintiff mailed a questionnaire to 50 independent pharmacies in the Portland area and received 32 replies. All 32 had provisions for emergency pharmacy service and 31 said they delivered prescriptions.

In the absence of a true "emergency" such as a person needing a drug immediately there is no justification for attempting to characterize as "emergency" the prescription drug sales the various hospitals make to the general public.

9. In enacting what is now 15 U.S.C. 13c the Congress granted eleemosynary institutions such as hospitals exemption from the Robinson-Patman Act. The exemption is limited, however, to purchases for their own use, and some of the major drug companies recognize and enforce this vital limitation.

Exhibit C to this affidavit is a copy of the "HOSPITAL PRICE AGREEMENT" notice issued by Sandoz, a major drug manufacturer. It states in part:

> "However, these purchasing privileges impose certain obligations on the purchaser and on Sandoz, as defined by Federal law.

"As a result, all products purchased from this Hospital Price List must be *stored and dispensed exclusively within the confines of the purchasing institution* and used exclusively in prescriptions for patients of the institution and for no other purpose.

(no paragraph)

Should the original purchasing institution resell such purchased products to any other users or to resellers of drugs — wholesale, retail, hospital, physician, nursing home, clinic or any other category — Federal law is thereby violated." (Emphasis by Sandoz)

[R. 647]

Exhibit D to this affidavit is a copy of a March 7, 1973 letter to your affiant signed by Governor Tom McCall. It states in part:

> "The University of Oregon Medical School explored the possibility of providing prescription drugs to the private patients of staff physicians.
>
> (no paragraph)
>
> *After their investigation of the administrative and legal requirements, the plan was abandoned.*" (emphasis supplied)

In other words, the State of Oregon recognized that drugs purchased under U.S.C. § 13c were to be used exclusively for hospital patients. A private patient of a staff physician is not a hospital patient.

Exhibit D is offered to reflect the official policy

of the State of Oregon concerning interpretation of the 15 U.S.C. § 13c exemption.

10. Eleemosynary hospitals were granted the 15 U.S.C. § 13c exemption to enable them to provide medical care at the lowest possible cost and it was assumed, naturally, that the savings would be passed on to the patients.

Instead, the plaintiff has established that the various alleged "nonprofit" hospitals have abused the privilege by selling drugs to doctors and employees at or below cost when overhead is taken into account and by overcharging patients and members of the public.

Welfare records I have examined during the past several months establish that various of the alleged "nonprofit" hospitals charge patients more for drugs than the average charge for the same quantity and quality of drugs sold by a community pharmacy and in excess of the maximum prices allowed by a State Welfare Division pursuant to state law and regulation.

Appendix 1 to this affidavit is a bulky publication titled: "PHARMACEUTICAL SERVICES(,) Guide for Public Welfare Medical Assistance Programs(,) BOOK B, SECTION III," with a covering letter dated December 1, 1972, signed by M. R. Arbuckle, Acting Medical Director, Medical Assistance Section, State Public Welfare Division, received April 4, 1973.

[R. 648]

Following page 38 of Appendix 1 is a group of basic drug lists and maximum drug prices, most of which bear the uniform statement:

"THE PRICE TO BE PAID BY THE PUBLIC WELFARE DIVISION FOR ANY DRUG IN THIS SCHEDULE WILL BE BILLED BY THE PHARMACIST AT THE LESSER OF (1) THE CEILING PRICE QUOTED IN THIS SCHEDULE, OR (2) THE USUAL AND CUSTOMARY CHARGE BY THE PHARMACIST TO THE GENERAL PUBLIC.

"THE 'CODE' NUMBER TOGETHER WITH THE 'COLUMN CODE LETTER' IS YOUR FEE SCHEDULE NUMBER FOR BILLING PURPOSES.

"PRICES IN THIS SCHEDULE ARE SUBJECT TO CHANGE."

The Public Welfare Division audits community pharmacies to insure that the community pharmacies charge the state no more than the ceiling price listed in Appendix 1 or the price the pharmacy charges other customers, whichever is lower.

However, the Public Welfare Division does *not* audit hospitals to insure that the "nonprofit" hospitals charge the state no more than the ceiling price listed in Appendix I or the price the pharmacy charges other customers, whichever is lower.

Nor are hospital drug charges to the state or the federal government audited by the HEW Audit Agency of the U. S. Department of Health, Education, and Welfare.

Consequently, the alleged "nonprofit" hospitals charge for drugs sums substantially in excess of the ceiling prices listed in Appendix 1 and even more substantially in excess of the prices charged doctors and employees.

Page 15 of the Howard Steinbach affidavit reviews the record that confirmed that Emanuel Hospital overcharged the state on a welfare prescription. Mr. Fawkes confirmed my earlier affidavit on the point.

[R. 649]

I know of my own personal knowledge as a community pharmacist that the State Public Welfare Division audits community pharmacies to ascertain whether they are complying with the provisions of Appendix 1, which I hereby certify is an official State Public Welfare Division document received by me from said agency. I have been told by state and federal officials that their respective agencies do not audit hospital bills submitted to the State Public Welfare Division and have personally confirmed these disclosures by my personal examination of hospital bills filed by the hospitals as official records of the State Public Welfare Division. I was able to obtain access to said documents by certifying that I would not use them for political purposes.

11. Exhibit F to this affidavit consists of copies

of Providence Hospital billing summaries the hospital submitted to the State Public Division [sic]. They are official records of said state agency. I hereby certify that exhibit documents are exact copies of the originals, subject to the exception that pursuant to state and federal law and regulation, the agency obliterated the names of the welfare recipients to protect their identities. Otherwise, they are true and correct copies.

On patient number 212081 the hospital charged the state $3.95 for 12 Ampicillin 250 mgm when the state ceiling is $2.90. Providence charged $4.25 for 3 Dexamethasone 1.5 mgm when the state ceiling is $1.75. Providence charged $14.25 for 3 Mucomyst 20% when the state ceiling is $9.85. Providence charged $3.15 for 6 Parest 400 mgm when the state ceiling is $1.39.

12. Exhibit G to this affidavit consists of copies of Portland Adventist Hospital billing summaries the hospital submitted to the State Public Welfare Division, and I certify the exhibit is true and correct. Portland Adventist charged $26.95 for 15 Demerol injections. The highest and most expensive form of Demerol (100 mgm in 2 cc. disp. syringes) costs $4.94, according to the 1973 Redbook. The state ceiling is $8.26. Portland Adventist billed $19.25 for 11 doses of Penergan injection 25 mgm. The high Redbook price to the state would be $9.66.

[R. 650]

On serial number RO 3049 of Exhibit D Portland Adventist Hospital billed the State Welfare Division $3.10 for 2 Noctec 7¼ grains. The state ceiling would allow an assignor $2.65 for the same drug.

On serial number RO 3059 of Exhibit D Portland Adventist Hospital billed the State Public Welfare Division $70 for 40 by 40 mg IM Talwin injection. The state ceiling for that drug in that quantity is $22.69. In the same billing we find that Portland Adventist Hospital billed the State Public Welfare Division $5.20 for one eight oz. bottle of Kaon. If an assignor could bill for this drug, he would be allowed $3.69.

13. The above exhibits were analyzed to provide further evidence that the alleged nonprofit hospitals do *not* sell to their patients at the lowest possible cost —the rationale for the 15 U.S.C. § 13c exemption— but sell their drugs far in excess of costs and the state ceilings on drugs paid for by the state through the various welfare programs.

14. Every part of this affidavit is based on my personal knowledge. I personally, for example, obtained from the Multnomah County Department of Taxation computer print-outs that listed the Bess Kaiser Hospital as partly on the Multnomah county tax roll, and this knowledge was confirmed by Mr. Kermit M. Carson during his deposition, which I attended.

I have personal knowledge of the facts set forth on page 4 of this affidavit concerning the West Hills Pharmacy, which is operated by the corporation of which I am the President. The prescriptions listed on page 4 of my affidavit were obtained by me and were in my personal possession until transferred to plaintiff's counsel in connection with the preparation of this affidavit. I have personal knowledge of the prescriptions listed on page 5 of my affidavit. They are unopened and unused and were in my personal possession until transferred to plaintiff's counsel in connection with the preparation of this affidavit.

I affirm that Exhibit C is a true copy of the notice issued by Sandoz.

[R. 651]

15. I certify that each of the exhibits attached to this affidavit are exact, true and complete copies of the originals, except that Appendix 1 is an official state document and not a copy thereof.

16. I certify that Exhibit B to this affidavit is a true and correct copy of the Carson deposition exhibits quoted at pages 2 and 3 of this affidavit. I further certify that Exhibit D is a true and exact copy of the letter written to me by Governor Tom McCall in response to my inquiry, that I received said exhibit through the United States mails and that it is signed by the Governor, and that said exhibit was in my personal possession until I transferred it to plaintiff's counsel in connection with preparation of this affidavit.

17. Defendants have moved to strike various of plaintiff's Rule 56 affidavits, including all documents incorporated by reference in or attached as exhibits to said affidavits. I am personally aware of the contents of the various challenged Rule 56 affidavits, personally assisted in the preparation of various of the affidavits, e.g., analyzed the depositions and exhibits and made reports of my findings and conclusions to plaintiff's counsel, was fully aware of the contents of various of the affidavits before they were executed, and make the following statements under oath on my personal knowledge as to the following challenged affidavits:

(a) PLAINTIFF'S RULE 56 AFFIDAVIT IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION, Henry Kane affidavit executed March 19, 1973.

Mr. Kane was the most knowledgeable person to prepare and execute said affidavit on behalf of plaintiff, which was prepared in consultation with your affiant, Logan Wallace and Howard Steinbach and is to a large extent based on the official trial court file—the depositions and the exhibits to said depositions. The affidavit quotes the Raymond L. Montee affidavits, which defendants have not challenged. On page 20 and 21 [sic] of the March 19, 1973 Kane affidavit are quotations from Wong Providence Hospital deposition exhibits 13 and 14. I certify that I received the originals of said deposition exhibits, that they were in

[R. 652]

my personal possession until transferred to plaintiff's counsel for purposes of the instant case, and I certify that said exhibits are true and complete copies of the originals thereof. I further certify that exhibits A and B to the March 19, 1973 affidavit were taken from documents in my personal possession until transferred to plaintiff's counsel for purposes of the instant case, and I certify that said exhibits are true and complete copies of the original thereof.

(b) RULE 56 AFFIDAVIT OF HOWARD STEINBACH IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION, Howard Steinbach affidavit executed March 29, 1973.

I certify that Exhibit A to the Steinbach affidavit is a true and complete copy of a document prepared by the Oregon State Board of Pharmacy and made available to plaintiff, and that said document was prepared by said agency from the official records of said agency.

I certify that Exhibit B and Exhibit B-1 are accurate representations of the facts set forth therein and that the data on pharmacy closures are taken from the official records of the Oregon State Board of Pharmacy.

I certify that Exhibit C is a true and original official form of the State Public Welfare Division and

that said exhibit was obtained by the plaintiff directly from the State Public Welfare Division. I know of my own personal knowledge that the form designated Exhibit C is used in the regular course of business by the State Public Welfare Division.

DATED: April 9, 1973.

(Subscription, jurat, and certificate of service omitted in printing)

[R. 688]

United States District Court for the District of Oregon

PLAINTIFF'S RULE 56 AFFIDAVIT OF RAYMOND L. MONTEE RE "CHARITABLE" NATURE OF BESS KAISER HOSPITAL, PORTLAND, ORE.

(Filed April 16, 1975; caption omitted in printing)

STATE OF OREGON)
)ss.
County of Multnomah)

I, Raymond L. Montee, being first duly sworn, depose and say:

1. I am the President of R. L. Montee & Associates, specialized services for the professional man, 3924 N. Interstate Ave., Portland, Oregon 97227, and in that capacity was retained by the law firm of Tilbury & Kane to make inquiry to determine whether Bess Kaiser Hospital, Portland, Oregon, admitted non-emergency, "charity" or medically indigent patients for treatment.

2. On April 10, 1973, your affiant and his female operator contacted Mr. Meadack (spelling?), supervisor of admissions at said hospital, and listened courteously to the inquiry of the female operator as to whether the Bess Kaiser Hospital would admit a personal friend who required medical attention. It was made clear that the prospective patient is without insurance, income or personal property and if admitted to the hospital, could not pay for hospital services received.

[R. 689]

3. Mr. Meadack said that if the woman were an emergency case, the Bess Kaiser Hospital, like most other hospitals, would not be likely to turn the patient away.

4. Mr. Meadack then indicated his belief that it was Bess Kaiser Hospital policy to refer this type of non-emergency patient to the Multnomah County Hospital.

5. Mr. Meadack did not commit himself or the hospital as to whether Bess Kaiser Hospital would admit the prospective patient. Instead, he indicated that he would personally inquire of the hospital administrator to find out if they could help or if there was anything that they might be able to do to help this seemingly deserving person.

6. On April 11, 1973, Mr. Meadack telephoned my office as he had promised to do the preceding day and said that hospital policy would not allow the hospital

to admit the prospective patient unless she were an emergency case. In the absence of an emergency, he said, she would be referred to the county welfare office for assistance. He said "their policy could not admit a medically indigent person without being an emergency case."

(Subscription, jurat and certificate of service omitted in printing)

[R. 691]

United States District Court for the District of Oregon

PLAINTIFF'S BRIEF IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION

(Filed April 16, 1973; caption omitted in printing)

• • • • •

[R. 696]

THE 'DE MINIMIS' EXCUSE DOES NOT APPLY TO THE MOTION

Whether the defendants have violated the Robinson-Patman Act is not dependent on the extent of the violation. The issue is whether the defendants have violated the statute, not whether the activity complained of is sufficiently large to constitute a violation of the Robinson-Patman Act.

• • • • •

Case-Swayne Co., Inc. v. *Sunkist Growers, Inc.*, supra, held that the Sunkist growers cooperative lost its exemption from the antitrust laws because *15 percent* of the local associations were private corporations or partnerships for profit instead of exempt growers. There was no discussion by the Supreme Court as to whether 15 percent was sufficient; it was assumed as a matter of course.

* * * * *

[R. 699]

In the case at bar there is no provision of the Robinson-Patman Act that limits its operation to any specific minimum volume of interstate commerce, and, of course, defendants have suggested none.

All of the drugs sold by the 14 alleged "nonprofit" hospitals are manufactured outside of the State of Oregon with respect to the defendants herein, hence all of defendants' drugs resold by the 14 alleged "nonprofit" hospitals are in interstate commerce.

* * * * *

[R. 702]

The Court should consider significant that *not one defendant herein has submitted the affidavit of an officer or employee in support of defendants' motion for summary judgment!*

There is a complete absence of such affidavits despite the fact that F.R.Civ.P. Rule 56 contemplates

that the court will consider the affidavits and counter-affidavits of the parties in ruling on motions for summary judgment.

* * * * *

[R. 711]

The evidence is uncontradicted that on two occasions persons were compelled to purchase so-called "take-home" drugs against their wishes, and defendants' memorandum is silent as to that matter.

Allan T. Carlston, 3707 S. E. Cooper, Portland, Oregon, district traffic representative for the Southern Pacific Transportation Company, testified on December 19, 1972, concerning his experience on June 26, 1972 at Emanuel Hospital, one of the 14 alleged "nonprofit" hospitals:

> "Q Will you relate what happened?
>
> "A Well, on or about that date I was informed that my father was released from the hospital so approximately 9 o'clock in the morning I was there to pick him up because the doctor hadn't arrived to sign a release.
>
> "* * * I said to the girl, 'Well, I am in quite a big hurry and would you give me the prescription so that I can take it to our druggist and have it filled close to home?'

[R. 712]

She said, 'No, it would have to be filled by the pharmacist in the hospital' * * *.

* * * * *

"Q Do you recall any other conversation with this young woman you identified as a nurse concerning the drug prescriptions?

"A *No, only that she said it had to be filled with the pharmacy at the hospital.*

"Q Did you ask for the prescriptions so that you could take them with you?

"A Yes, I did.

"Q What did she say, if anything?

"A *She said, no, they had to be filled at the pharmacy at the hospital.* * * *" (emphasis supplied) (Carlston deposition p. 3, lines 22-25; p. 4, lines 1-2, 8-17; p. 6, lines 4-14)

Mrs. Betty Marie Pye, 12601 S. E. Bush, Portland, was a patient at Portland Adventist Hospital when she received a so-called "take-home" prescription despite her expressed wish to have the prescription filled elsewhere:

* * * * *

[R. 713]

* * * * *

The above-noted depositions may help to explain why the various alleged "nonprofit" hospitals fill so many so-called "take-home" prescriptions. They are filled as a matter of hospital policy, regardless of the person's wishes and charged to the patient's hospital bill, not for the "convenience" of the person, but to enable the hospital to make a substantial profit on "take-home" drug sales to a captive market that otherwise would purchase drugs from the hospital's competitors.

* * * * *

[R. 714]

* * * * *

INTERNAL REVENUE SERVICE RULINGS SUPPORT PLAINTIFF

It is elementary that an agency's interpretation of a statute it administers, while not binding, is persuasive.

Exhibit A to this memorandum are true copies of the following Internal Revenue Service rulings relating to hospital drug sales, found in Internal Revenue Service Cumulative Bulletin 1968-2, July 1968:

Rev. Rul. 68-374 — Circumstances in which an exempt hospital derives unrelated business taxable income from the sale of pharmaceu-

tical supplies to the general public.

Rev. Rul. 68-375 — The sale of pharmaceutical supplies by an exempt hospital to private patients of physicians with offices in a hospital-owned medical building constitutes unrelated business.

Rev. Rul. 68-376 — Situations in which persons who purchase pharmaceutical supplies from an exempt hospital are considered "patients" of the hospital for purposes of determining whether the hospital is engaged in unrelated business.

Rev. Rul. 68-374 said of a situation involving a hospital pharmacy open to the public:

[R. 715]

* * * * *

"Furthermore, there is no substantial causal relationship between the achievement of the hospital's exempt purposes and the sale of pharmaceutical supplies to members of the general public who do not otherwise avail themselves of the hospital's medical or diagnostic facilities.

(no paragraph)

Therefore, *this sales activity constitutes the conduct of unrelated trade or business within the meaning of section 513 of the Code.*

* * * * *

"Accordingly, *the income derived by the hospital from the sale of pharmaceutical supplies to the general public constitutes 'unrelated business taxable income' as defined in section 512 of the Code.*" (emphasis supplied)

Two of the alleged "nonprofit" hospitals, Kaiser and Willamette Methodist, pay federal income taxes on their nonpatient drug sales. Kaiser agreed to pay in 1968 on the advice of counsel and therefore Kaiser is to this day paying taxes on drug sales in the Portland area that plaintiff contends are outside of the 15 U.S.C. § 13c exemption.

Rev. Rul. 68-374 also held that nominal drug sales by a hospital pharmacy to patients of doctors, but not patients of the hospital, constitute "unrelated trade or business [sic] as defined in section 513, since they are neither primarily for the convenience of the hospital's patients within the meaning of section 513(a)(2) nor substantially related to the exercise of the hospital's exempt purpose.

In the case at bar the evidence is uncontradicted that one of the 14 alleged "nonprofit hospitals, Gresham Community, has doctor's offices in the hospital. The hospital pharmacy and the doctor's offices

[R. 715]

are on the Multnomah County tax rolls along with the outpatient clinic and pharmacy at Bess Kaiser Hospital.

* * * * *

[R. 717]

The distinction between drugs sold to "outpatients" in connection with hospital treatment and nonpatient drugs outside the "outpatient" definition is made clear in *Harper* v. *Bankers Life & Casualty Company*, 151 SE2d 98 (S.C. 1966), originally cited to the court by defendants.

> "* * * Every patient who has been discharged from a hospital is not necessarily an outpatient of the hospital simply because his condition requires further treatment.
>
> (no paragraph)
>
> *In order to constitute one an outpatient of the hospital, the treatment received must be hospital connected.*" (151 SE2d 100) (emphasis supplied)

* * * Unless the drug sale was made incident to treatment of the purchaser by the hospital, the purchaser is a stranger to the hospital and its tax-exempt purpose. If made incident to outpatient treatment the drug is a "hospital order," not a prescription.

* * * * *

[R. 718]

Exhibit B to this memorandum is a true copy of a letter dated April 9, 1973, to plaintiff's counsel signed by C. H. Mack, Director of the Oregon Department of Revenue, in response to an inquiry as to whether the Kaiser Foundation Health Plan of Oregon, a membership organization, had been granted tax exemption by the Department of Revenue or its predecessor, the State Tax Commission.

Mr. Mack said:

> "We are not permitted under the provisions of ORS 314.835 to furnish the information requested. We can advise that Kaiser Foundation Health Plan of Oregon is not on our list of organizations contributions to which are deductible on Oregon tax returns of the donors."

In other words, Kaiser Foundation Health Plan of Oregon, whose members purchase nonpatient drugs from the Kaiser pharmacies, is not charitable or otherwise tax-exempt as to the State of Oregon.

See *Maynard Hospital, Inc.* v. *C.I.R.*, 52 Tax Court 1006 (1969) involving an alleged "nonprofit" hospital with strictly charitable services of less than one percent of the amount of its charged-for services and which operated a pharmacy for profit. The Tax Court held, *inter alia*, that the hospital was not operated exclusively for charitable purposes, and assessed taxes.

* * * * *

(Subscription omitted in printing)

[R. 721]

EXHIBIT A

Internal Revenue Bulletin, Cumulative Bulletin 1968-2
July 1968

§ 512.]

Circumstances in which an exempt hospital derives unrelated business taxable income from the sale of pharmaceutical supplies to the general public.

SECTION 512—UNRELATED BUSINESS TAXABLE INCOME

26 CFR 1.512(a)-1: Definition. Rev. Rul. 68-374
(Also Sections 501, 513; 1:501(c)(3)-1, 1:513-1.)

Advice has been requested as to the circumstances in which the sale of pharmaceutical supplies to the general public by the pharmacy of a hospital, exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954, results in unrelated business taxable income under section 512 of the Code.

Section 513 of the Code defines the term "unrelated trade or business" as any trade or business the conduct of which is not substantially related (aside from the need of such organization for income or funds or the use it makes of the profit derived) to the exercise or performance by such organization of its exempt functions.

To the extent relevant here, section 513(a)(2) of

the Code further states that the term "unrelated trade or business" does not include any trade or business which is carried on by an organization described in section 501(c)(3) primarily for the convenience of its patients.

Section 512 of the Code defines the term "unrelated business taxable income" as the income as computed in this section derived by organizations from any unrelated trade or business regularly carried on.

Section 1.513-1(c)(1) of the Income Tax Regulations states that in determining whether trade or business from which a particular amount of gross income derives is "regularly carried on" within the meaning of section 512, regard must be had to the frequency and continuity with which the activities productive of the income are conducted and the manner in which they are pursued.

Section 1.513-1(c)(2)(ii) of the regulations states that in determining whether or not intermittently conducted activities are regularly carried on, the manner of conduct of the activities must be compared with the manner in which commercial activities are normally pursued by non-exempt organizations. In general, exempt organization businesses which are engaged in only discontinuously or periodically will not be considered regularly carried on if they are conducted without the competitive and promotional efforts typical of commercial endeavors.

Section 1.513-1(c)(2)(ii) of the regulations further states that where an organization sells certain

types of goods or services to a particular class of persons in pursuance of its exempt functions "primarily for the convenience" of such persons within the meaning of section 513(a)(2), casual sales in the course of such activity which do not qualify as related to the exempt function involved or as described in section 513(a)(2) will not be treated as regular. On the other hand, where the nonqualifying sales are not merely casual, but are systematically and consistently promoted and carried on by the organization, they meet the section 512 requirement of regularity.

[R. 722]

The application of the principles and requirements set forth in the above sections of the Code and regulations to sales by a hospital pharmacy to members of the general public is illustrated in the two situations set out below.

Situation 1. A hospital exempt from Federal income tax under section 501(c)(3) of the Code maintains a facility on the ground floor of its main building for the sale of pharmaceutical supplies. In addition to prescription drugs, the pharmacy also sells nonprescription drugs and a few personal articles. The primary source of the pharmacy's income is sales to patients of the hospital. See Revenue Ruling 68-376, page 246, of this Bulletin, for illustrative descriptions of persons considered "patients" of a hospital. However, the pharmacy is also open to the general public. A small percentage of its income is from frequent and

continuous sales of prescription and nonprescription drugs to persons who are not patients of the hospital, but who walk in off the streets to make purchases from the pharmacy.

The buyer-seller relationship between these off-street patrons and the hospital pharmacy is not, in and of itself, sufficient to classify such persons as "patients" of the hospital. Therefore, sales to these persons cannot be considered primarily for the convenience of the patients of the hospital within the meaning of section 513(a)(2) of the Code.

Furthermore, there is no substantial causal relationship between the achievement of the hospital's exempt purposes and the sale of pharmaceutical supplies to members of the general public who do not otherwise avail themselves of the hospital's medical or diagnostic facilities. Therefore, this sales activity constitutes the conduct of unrelated trade or business within the meaning of section 513 of the Code.

The hospital pharmacy's facilities are freely available to patients and nonpatients alike. Pharmaceutical sales to the general public are frequent and continuous and are thus regularly carried on within the meaning of section 512 of the Code.

Accordingly, the income derived by the hospital from the sale of pharmaceutical supplies to the general public constitutes "unrelated business taxable income" as defined in section 512 of the Code.

Situation 2. A hospital exempt from the Federal

income tax under section 501(c)(3) of the Code maintains a limited number of consultation and examination rooms that are available to its medical staff for treating their private patients. These rooms are used only when it is mutually convenient for the patient and physician to meet at the hospital. Patients visiting their physicians in these rooms are not patients of the hospital. If, during the course of such visits, the patient receives a prescription from his physician, he may fill it at any pharmacy.

The hospital maintains a pharmacy for the use of its own patients. Sales to non-patients are not ordinarily permitted. However, as a courtesy to its medical staff, the pharmacy will occasionally fill prescriptions written by the physicians for their private patients, but such sales are not promoted by the hospital, do not occur with frequency, and represent only an insignificant portion of the pharmacy's total sales.

Under these circumstances, such sales would constitute unrelated trade or business as defined in section 513, since they are neither primarily for the convenience of the hospital's patients within the meaning of section 513(a)(2) nor substantially related to the exercise or performance of the hospital's exempt purposes. However, in view of the manner in which they are conducted, these nonqualifying sales are considered casual sales within the meaning of section 1.513-1(c)(2)(ii) of the regulations. Income derived from such sales does not constitute income derived from unrelated trade or business that is regularly carried on

and, therefore, does not constitute "unrelated business taxable income" within the meaning of section 512 of the Code.

[R. 723]

• • • regardless of the number of unrelated businesses. When drafting the 1954 Code, Congress intended no substantive changes from section 421(c) of the 1939 Code. See S. Rept. 1622, 83d Cong., 312 (1954).

Accordingly, the organization is entitled to only one $1,000 deduction under section 512(b)(12) of the 1954 Code in computing its unrelated business taxable income regardless of the number of unrelated businesses in which it is engaged.

The sale of pharmaceutical supplies by an exempt hospital to private patients of physicians with offices in a hospital-owned medical building constitutes unrelated business.

SECTION 513.—UNRELATED TRADE OR BUSINESS

26 CFR 1.513-1:Definition of unrelated trade or business. Rev. Rul. 68-375

(Also Section 501; 1.501(c)(3)-1.)

Advice has been requested whether, under the circumstances set forth below, the sale of pharmaceutical supplies by a hospital exempt from Federal income tax under section 501(c)(3) of the Internal Revenue

Code of 1954 is unrelated business within the meaning of section 513 of the Code.

The hospital owns a medical office building located adjacent to the hospital. It leases office space to those members of its medical staff who find it convenient to locate their private practice in proximity to the hospital. The office practice of these physicians is independent of any activities in which they engage as members of the hospital's medical staff. Patients visiting their offices are treated as their private patients. The hospital's governing authority over the treatment of hospital patients by its medical staff does not extend to the services rendered by the physicians in their private office.

The hospital operates a pharmacy in the office building. It is maintained for the convenience of those persons visiting their private physicians in the building. Income of the pharmacy is primarily from the sale of prescription and nonprescription pharmaceutical supplies to the private patients of the physicians practicing in the building.

Section 513 of the Code defines the term "unrelated trade or business" as any trade or business, the conduct of which is not substantially related (aside from the need of such organization for income or funds or the use it makes of the profits derived) to the exercise or performance by such organization of its exempt functions.

To the extent relevant here, section 513(a)(2) of the Code further states that the term "unrelated trade

or business" does not include any trade or business which is carried on by an organization described in section 501(c)(3) primarily for the convenience of its patients.

Section 1.513-1(d)(2) of the Income Tax Regulations states that a trade or business is "related" to exempt purposes only where the conduct of the business activity has a causal relationship to the achievement of an exempt purpose; and is "substantially related" for purposes of section 513 only if the causal relationship is a substantial one.

[R. 724]

Pharmaceutical supplies are purchased from this pharmacy as an incident to the purchaser's visit to his private physician, rather than as an incident to his use of any of the hospital facilities.

The sale of pharmaceutical supplies to these persons cannot therefore be considered a trade or business that is carried on by the hospital primarily for the convenience of its patients within the meaning of section 513(a)(2) of the Code. Furthermore, since these customers are not patients of the hospital, there is no substantial causal relationship between the achievement of the hospital's exempt purposes and the sale of pharmaceutical supplies to them. Therefore, this activity is not substantially related to the exercise or performance of the hospital's exempt functions within the meaning of section 513 of the Code and implementing regulations.

Accordingly, the sale of pharmaceutical supplies to the class of persons and under the circumstances described above constitutes the conduct of unrelated business within the meaning of section 513 of the Code.

Situations in which persons who purchase pharmaceutical supplies from an exempt hospital are considered "patients" of the hospital for purposes of determining whether the hospital is engaged in unrelated business.

26 CFR 1.513-1: Definition of unrelated trade or business. Rev. Rul. 68-376

(Also Section 501; 1.501(c)(3)-1.)

The Internal Revenue Service has been requested to set forth situations in which persons who purchase pharmaceutical supplies from the pharmacy of a hospital exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954 are considered "patients" of the hospital within the meaning of section 513(a)(2) of the Code.

Section 513 of the Code defines the term "unrelated trade or business" as any trade or business the conduct of which is not substantially related (aside from the need of an organization for income or funds or the use it makes of the profits derived) to the exercise or performance by an organization of its exempt functions. However, to the extent relevant here, section 513(a)(2) of the Code further states that such term does not include any trade or business which is

carried on by an organization described in section 501(c)(3) primarily for the convenience of its patients.

In the case of a hospital exempt under section 501(c)(3) of the Code, the sale of pharmaceutical supplies by its pharmacy to persons considered "patients" of the hospital does not constitute unrelated trade or business as defined in section 513 of the Code. See section 1.513-1(c)(2)(ii) of the Income Tax Regulations. Depending upon his relationship with the hospital, a purchaser of pharmaceutical supplies from the pharmacy of a hospital exempt from Federal income tax under section 501(c)(3) of the Code may be considered a "patient" of the hospital as that term is used in section 513(a)(2) of the Code.

Examples of relationships that determine whether a person is a "patient" of a hospital for purposes of section 513(a)(2) of the Code are illustrated in the six situations set out below.

Situation 1—A person admitted to a hospital as an inpatient.

A is admitted to the hospital as an inpatient. He receives bed, meals, diagnostic services, and treatment for his illness. He is a "patient" of the hospital.

Situation 2—A person receiving general or emergency diagnostic, therapeutic, or preventive health services from outpatient facilities of a hospital.

B is taken to the hospital's emergency room for treatment of injuries sustained in an accident. He is treated in the emergency room and discharged, but is told to return to the hospital's outpatient clinic for further treatment. The hospital maintains an outpatient clinic having regularly scheduled hours during which medical services are provided on an outpatient basis. The governing authority of the hospital has full legal responsibility for the conduct of the clinic. *B* visits the clinic, is registered as a patient, and receives medical care. Treatment in either the emergency room or the outpatient clinic is sufficient to make *B* a "patient" of the hospital.

Situation 3—A person directly referred to the hospital's outpatient facilities by his private physician for specific diagnostic or treatment procedures.

C's private physician refers him to the hospital's outpatient diagnostic facilities for a specific diagnostic procedure. The procedure is administered by a hospital-based practitioner affiliated with the hospital. The availability of these diagnostic procedures is an integral part of the services offered by the hospital. *C* is a "patient" of the hospital.

Situation 4—A person refilling a prescription written during the course of his treatment as a patient of the hospital.

D was formerly a patient of the hospital. During his course of treatment the attending staff physician gave *D* a prescription. *D* filled the prescription at the hospital pharmacy, which filed and retained it. After formal discharge as a patient, he finds it convenient to return to the hospital pharmacy to obtain a refill of that prescription. Since the prescription was written in the course of the hospital-patient relationship, *D* is a "patient" of the hospital.

Situation 5—A person receiving medical services as part of a hospital administered home care program.

E receives medical services in his residence. The services are rendered by, and under the supervision of, the professional staff of the hospital as an extension of its inpatient and outpatient care. *E* is a "patient" of the hospital.

Situation 6—A person receiving medical care and services in a hospital-affiliated extended care facility.

F is a patient in an extended care facility qualified to participate in Medicare and other government financed programs. The facility is affiliated with the hospital which, by agreement, is responsible for certain of its professional activities, especially those necessary to qualify the facility for participating in the Medicare program. While a patient in the facility, *F* is under the medical supervision of a mem-

[sic]

ber of the hospital's medical staff and thus is a "patient" of the hospital.

Accordingly, sales of pharmaceutical supplies to the "patients" in each of the situations described do not constitute unrelated trade or business of the hospital within the meaning of section 513 of the Code.

See Revenue Rulings 68-374 and 68-375, pages 242 and 245 of this Bulletin, for other situations involving sales of pharmaceutical supplies by pharmacies operated by hospitals.

(Certificate of service omitted in printing)

[R. 728]

United States District Court for the District of Oregon

SECOND RULE 56 AFFIDAVIT OF STANLEY HARTMAN IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION, RE PREFERENTIAL DRUG PRICES OF LISTED DEFENDANTS

(Filed April 23, 1973; caption omitted in printing)

STATE OF OREGON)
)ss.
County of Multnomah)

I, Stanley Hartman, being first duly sworn, depose and say:

1. I am a registered pharmacist licensed by the State of Oregon, am engaged in the practice of pharmacy as a community pharmacist, am a member of plaintiff, Portland Retail Druggists Association, Inc., am an officer of one of the assignors herein, have attended various of the drug practices depositions taken by plaintiff, have read and studied defendants' memorandum in support of their motion for summary judgment on the plaintiff's Second Cause of Action, am familiar with the drug sale practices of the various defendants as they pertain to community pharmacies, am competent to make this affidavit concerning the matters stated herein, and make this affidavit on my personal knowledge in opposition to defendants' motion for summary judgment on plaintiff's Second Cause of Action pursuant to Rule 56(e) of the Federal Rules of Civil Procedure.

[R. 729]

2. The Court ordered the plaintiff *not* to make inquiry during deposition discovery of chief pharmacists and other officials of alleged "nonprofit" hospitals concerning defendants' preferential prices, terms and conditions received by said hospitals which are not made available to plaintiff's assignors and other Portland-Vancouver area community pharmacies in competition with said hospitals for the retail trade of "walk-in" members of the general public and other nonhospitalized customers.

3. This affidavit is made to fill in part of the missing record material to defendants' motion for summary judgment on plaintiff's Second Cause of Action, although the record will not be complete until plaintiff receives answers to its August 6, 1971 interrogatories to defendants and is allowed to make discovery of evidence in the sole possession of defendants, e.g., diversion of drugs from said hospitals.

4. Exhibit A to this affidavit is a copy of a form letter dated January, 1973, issued by defendant Abbott Laboratories and personally received by your affiant as a community pharmacy of said defendant in the regular course of business.

5. Exhibit A states in part:

> "Thirdly, because of constantly increasing costs of distribution, we find it necessary to raise our minimum prepaid order to $50.00. Orders of less than $50.00 received after February 1, 1973, will be assessed a $2.00 handling charge. * * *"

6. Exhibit B to this affidavit is a series of the published prices, terms and conditions at which defendants Abbott, Bristol, Squibb, the Warner-Chilcott division of defendant Warner-Lambert Pharmaceutical Company and the Ayerst and Wyeth Laboratories divisions of defendant American Home Products Corporation sell drugs to favored hospitals.

7. The price sheets for Erythromycin, Penicillin and Hydrochlorothiazide issued by defendant Abbott Laboratories and set forth on page 1 of Exhibit A state with respect to "MINIMUM ORDER:"

[R. 730]

> "*None;* however, every effort should be made to keep small orders to a minimum." (emphasis supplied)

In other words, Abbott requires the community pharmacy to place a minimum order of $50 or be assessed a $2 handling charge, but accepts orders from hospitals without any minimum requirement.

8. Defendant E. R. Squibb & Sons, Inc. issued a price list dated January, 1973, which was received by your affiant in the regular course of business from said defendant. The Squibb Pharmaceutical Company price list states under "TERMS AND CONDITIONS OF SALE:"

> "* * * On orders of less than $50.00 net from retail accounts, a service charge of $2.00 will be added."

9. However, the Squibb price sheets for Ampicillin, Tetracyline, and Penicillin in Exhibit B to this affidavit all state:

> "MINIMUM ORDER: None; however, every effort should be made to keep small orders to a minimum."

In other words, Squibb has no minimum order requirement for certain hospitals, but requires a community pharmacy to pay a $2 handling charge if the community pharmacy's order is less than $50.

10. After comparing the prices set forth in Exhibit B with the prices set forth in defendants' catalogs in my possession as a community pharmacist, I state that the defendants whose price lists are set forth in Exhibit B sell the listed drugs to certain hospitals for substantially less than said defendants sell drugs of the same designation, quality and quantity to your affiant and other operators of community pharmacies in the Portland area of the State of Oregon.

11. Exhibit B discloses that Abbott Laboratories sells Penicillin V Potassium tablets 125 mg bulk for $1.95 per 100. The price to the community is $5.37. Abbott sells Hydrochlorothiazide 50 mg tablets at $29.50/1000 to certain hospitals. The price to the community pharmacy is $41.18. Similarly, the community pharmacy pays $9.00 for Erythromycin ethyl succinate 200 mg tablets which Exhibit A shows Abbott sells to certain hospitals for $8.55/50.

[R. 731]

12. Exhibit B to this affidavit discloses that defendant Bristol-Myers Company sells Erythromycin 250 mg base Bristamycin $8367-60 [sic] to certain hospitals for $7.25 per 100. The community pharmacy pays $9.48 for the same drug and quantity.

13. Exhibit B to this affidavit discloses that defendant American Home Products Corporation's Ayerst Laboratories Division sells Dicloxacillin 250 mg capsule Veracillin #46-661-81 for $6.27 per 100. The price to the community pharmacy for the same drug and quantity is $21.45 if purchased directly and $23.83 if purchased through a drug wholesaler.

14. Exhibit B to this affidavit discloses that defendant American Home Products Corporation's Wyeth Laboratories Division sells Omnipen #8-55-1 250 mg/5cc 80 ml bottles for $0.79/80cc. The community pharmacy pays $2.26.

15. Exhibit B to this affidavit discloses that defendant American Home Products Corporation's Wyeth Laboratories Division sells Omnipen # 8-315-6 mg vial for $2.50/10. The community pharmacy pays $19.00.

16. Exhibit B to this affidavit discloses that defendant American Home Products Corporation's Wyeth Laboratories Division sells Omnipen #8-315-9 1,000 mg vial for $4.50/10. The community pharmacy pays $26.00.

16. Exhibit B to this affidavit discloses that defendant American Home Products Corporation's Wyeth Laboratories Division sells Equanil 1R481 400 mg tablets for $12.36/500 and Equanil 1P481 400 mg tablets for $24.50/1000 to certain hospitals. The community pharmacy pays $29.50 and$ 58.00, respectively, for the same quantity of said drugs.

17. Exhibit B to this affidavit discloses that defendant American Home Products Corporation's Wyeth Laboratories Division sells Bicillin LA 6000MU Tubex pgh of 10's at $8.75/pkg for one to nine packages and $8/pgh for 10 to 99. The community pharmacy pays $13.46 and $12.08, respectively, for the same quality and quantity of said drug.

18. Exhibit B to this affidavit discloses that defendant American Home Products Corporation's Wyeth Laboratories Division sells Bicillin

[R. 732]

LA 1200 OMU Tubex pkg. of 10's at $15/pkg for one to nine packages and at $14/pkg. for 10 to 99 packages. The community pharmacy pays $23.24 and $20.92, respectively, for the same quality and quantity of said drugs purchased from said defendant. Not available to the community pharmacy are the quantity discounts for said drugs in quantities of 100 or more, although available to certain hospitals.

19. Exhibit B to this affidavit discloses that de-

fendant Squibb also sells drugs to certain hospitals at prices far below those charged to community pharmacies in this area. Listed below at the left is the Squibb drug, the center column lists the Squibb price to certain hospitals, and the column to the right lists the price to the community pharmacy for the same quality and quantity of drug:

Name	Hospital Price	Community Pharmacy Price
Principen-N #9716	$17.40/500	$60.67
Principen-N #9715	3.85/100	12.67
Principen-N #9745	6.50/100	24.83
Principen-N #97451	6.75/100	24.83
Sumycin #6556	13.75/1000	38.50
Sumycin #65546	1.75/100	4.25
Sumycin #7634	3.15/100	8.25
Sumycin #76346	3.15/100	8.25
Sumycin #8156	.42/60 ml	.90
Sumycin #8155	1.98/480 ml	4.95
Penicillin #6346	5.88/50	10.50
Penicillin #67374	6.50/25	22.50
Penicillin #7341	.55/ea	1.80
Penicillin #7353	1.05/ea	3.20
Penicillin #6846	1.99/100	7.05
Penicillin #6485	3.95/100	12.68
Penicillin #6814	.49/bottle	1.30
Penicililn #6824	.69 bottle[sic]	1.68

[R. 733]

20. I certify that Exhibit A to this affidavit is a true and correct copy of the original thereof.

21. I certify that the documents comprising Exhibit B to this affidavit are true and correct copies of the originals thereof except for the portions I have deleted to avoid disclosure at this time of the source of said documents. The original documents comprising Exhibit B are available to the Court for *in camera* inspection.

DATED: April 21, 1973.

(Subscription, jurat and certificate of service omitted in printing)

[R. 751]

United States District Court for the District of Oregon

ORDER

(Filed May 4, 1973; caption omitted in printing)

IT IS ORDERED:

1. Plaintiff's motion, dated December 7, 1972, for an Order that Portland Adventist Hospital, by and through Donald R. Ammon, shall produce, pursuant to the previously served Deposition Subpoena Duces Tecum, documents evidencing the net revenue from the pharmacy operations of said hospital, and shall answer deposition questions pertaining to the net revenue from the pharmacy operations of said hospital, is granted.

2. Plaintiff's motion, dated December 19, 1972, for an Order that Kaiser Foundation Hospitals, by and through its Regional Controller, Robert A. Scott, shall answer deposition questions as to the Kaiser-affiliated organization he deems to be the owner of drugs transferred from the Bess Kaiser Hospital, Portland, Oregon, to pharmacy clinics in the Portland-Vancouver area operated by Permanente Services of Oregon, Inc., an Oregon for profit corporation, is granted.

[R. 752]

3. Plaintiff's motion, dated December 19, 1972, for an Order that Kaiser Foundation Hospitals, by and through its Regional Controller, Robert A. Scott, shall answer deposition questions as to whether Exhibit 28 to his December 14, 1972 deposition is an accurate representation of certain drug labels, is denied.

4. Plaintiff's motion, dated December 28, 1972, for an Order that defendants shall answer PLAINTIFF'S INTERROGATORIES TO DEFENDANTS (FIRST SET), dated August 6, 1971, as amended by PLAINTIFF'S AMENDED INTERROGATORIES TO DEFENDANTS (FIRST SET), dated November 23, 1971, is denied without prejudice to future renewal of said motion.

5. Plaintiff's motion, dated December 28, 1972, for an Order that plaintiff may file and serve its PLAINTIFF'S RULE 34 REQUEST FOR DOCUMENTS, attached to its motion dated October 25, 1972, is denied without prejudice to future renewal of said motion.

DATED this 4 day of May, 1973.

(Subscription omitted in printing)

[R. 754]

United States District Court for the District of Oregon

AFFIDAVIT OF STANLEY HARTMAN

(Filed May 18, 1973)

STATE OF OREGON)
)ss.
County of Multnomah)

I, STANLEY HARTMAN, being first duly sworn, depose and say:

1. I am a registered pharmacist licensed by the State of Oregon, am engaged in the practice of pharmacy as a community pharmacist, am a member of plaintiff, Portland Retail Druggists Association, Inc., am an officer of one of the assignors herein, have attended various of the drug practices depositions taken by plaintiff, have read and studied defendants' memorandum in support of their motion for summary judgment on plaintiff's Second Cause of Action, am familiar with the drug sale practices of the various defendants as they pertain to community pharmacies, am familiar with the prescription drug containers issued by the various hospitals whose chief pharmacists and other officials were deposed by plaintiff, am competent to make this affidavit concerning the matters stated herein, make this affidavit on my own personal knowledge, and make this affidavit pursuant to Rule 56(e) of the Federal Rules of Civil Procedure and pursuant to the desire of the Court for "numbers"

concerning drug practices of alleged "nonprofit" hospitals, and in opposition to defendants' motion for summary judgment on plaintiff's Second Cause of Action.

* * * * *

[R. 755]

* * * * *

7. Between December 26, 1967, when it issued prescription number 335096, and May 8, 1973, when it issued prescriptionn umber 546054, Emanuel Hospital issued *216,958* [sic] *new prescriptions*, plus a substantial but undetermined number of prescription refills. The Emanuel Hospital figure is exceeded by the *231,061 new prescriptions* issued by the Bess Kaiser Hospital alone between July 1, 1970 and April 12, 1973, a much shorter time period. The figures for the Permanente clinics are

[R. 756]

equally impressive in terms of numbers of prescriptions to non-hospitalized purchasers. The Beaverton Permanente Clinic pharmacy competes with my Bel-Aire Pharmacy in Beaverton for the trade and custom of retail drug purchasers in the Beaverton area of Oregon. The Beaverton Permanente Clinic pharmacy issued prescription number BT 41812 on October 8, 1970 and prescription number BT 144889 on April 27, 1973, or a total of *103,077 new prescriptions* during a period of less than three years.

8. Exhibit A to this affidavit also discloses that Providence Hospital issued 49,435 new prescriptions between August 23, 1968 and May 11, 1973.

9. Exhibit A to this affidavit also discloses that Portland Adventist Hospital issued 48,759 new prescriptions between March 29, 1969 and March 16, 1973.

10. Exhibit A to this affidavit also discloses that St. Vincent Hospital issued 38,045 new prescriptions between March 15, 1971 and March 9, 1973, a two-year period.

11. Exhibit A to this affidavit also discloses that Holladay Park Hospital issued 17,803 new prescriptions between February 2, 1971 and February 2, 1973, a two-year period.

12. Exhibit A to this affidavit, however, does *not* reflect sales to physicians by the hospitals for the office use of the physicians.

(Subscription, jurat and certificate of service omitted in printing)

United States District Court for the District of Oregon

THIRD RULE 56 AFFIDAVIT OF HOWARD STEINBACH IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION

(Filed May 23, 1973; caption omitted in printing)

STATE OF OREGON)
) ss.
County of Multnomah)

I, HOWARD STEINBACH, being first duly sworn, depose and say:

1. I make this motion in opposition to defendants' motion for summary judgment on plaintiff's Second Cause of Action.

2. I am a registered pharmacist licensed by the State of Oregon, a partner in the operation of three pharmacies in the metropolitan area of Portland, an assignor in the above-titled cause, have attended various of the drug practices depositions taken by plaintiff, have read and studied defendants' memorandum in support of their motion for summary judgment on plaintiff's Second Cause of Action, am competent to make this affidavit concerning the matters herein, possess personal knowledge concerning each of the matters stated herein, am familiar with the price lists issued by defendant E. R. Squibb & Sons, Inc., and have compared prices listed in said price lists for the comparable 1971 period with invoices issued by said defendant to various hospitals.

3. Listed below are drugs sold in 1971 by defendant E. R. Squibb to hospitals, the price listed on the Squibb invoice to the hospital, and the higher price to the community pharmacy for the same quantity of drug as set forth in the Squibb "PRICE LIST" to community pharmacies dated January 1971:

Drug	Hospital Price	Pharmacy Price
Pentids 300	$ 5.25	$ 6.25
Pentids P 600 A.S.	5.50	8.25
Delestrogen 20 mg/cc	1.22 per dose/ 50 doses	1.50
Noctec 7½ gr	2.00	4.20
Principen 250 mg cap	25.00	91.00
Principen 500 mg cap	9.25	37.25
Principen Powder 12	.60	2.18
Deladuomone 2 cc Unimatic	2.44	2.84
Sumycin Hydrochloride	168.00	180.00

4. The Squibb hospital invoice that lists Delestrogen 20 mg/cc at $1.22 per dose for a 50-dose order also lists 20 doses of the same drug as "BONUS" and makes no charge for the additional 20 doses. Therefore, the net hospital price is 87 cents per dose.

5. The invoice copies quoted in this affidavit are in the possession of plaintiff's counsel and are available for *in camera* inspection by the Court.

(Subscription, jurat and certificate of service omitted in printing)

United States District Court for the District of Oregon

FOURTH RULE 56 AFFIDAVIT OF STANLEY HARTMAN IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON PLAINTIFF'S SECOND CAUSE OF ACTION, RE DRUG PRICE OVERCHARGES BY BESS KAISER HOSPITAL, AN ALLEGED "NONPROFIT" HOSPITAL

(Filed May 23, 1973; caption omitted in printing)

STATE OF OREGON)
) ss.
County of Multnomah)

I, STANLEY HARTMAN, being first duly sworn, depose and say:

1. I am a registered pharmacist licensed by the State of Oregon, am engaged in the practice of pharmacy as a community pharmacist, am a member of plaintiff, Portland Retail Druggists Association, Inc., am an officer of one of the assignors herein, have attended various of the drug practices depositions taken by plaintiff, have read and studied defendants' memoranda in support of their motion for summary judgment on plaintiff's Second Cause of Action, am familiar with the drug sale

practices of the various defendants as they pertain to community pharmacies, am competent to make this affidavit concerning the matters stated herein, make this affidavit on my own personal knowledge, certify that each and every exhibit to this affidavit is a true and complete copy of the original thereof, and make this affidavit pursuant to Rule 56(e) of the Federal Rules of Civil Procedure in opposition to defendants' motion for summary judgment on plaintiff's Second Cause of Action.

2. This affidavit supplements the RULE 56 AFFIDAVIT OF HENRY KANE RE BESS KAISER HOSPITAL, AN ALLEGED "NONPROFIT" HOSPITAL, executed April 24, 1973. Exhibit A to the April 24, 1973 Kane affidavit was a copy of a letter to Mr. Kane dated April 23, 1973, signed by T. H. Hammond, Medical Fiscal Supervisor, Medical Assistance Section, Public Welfare Division, Oregon Department of Human Resources, which said in part:

> "*We are advised by the Kaiser Foundation* that except for OEO/Welfare clients, they no longer accept welfare clients as hospital patients. * * *" (emphasis supplied)

3. Bess Kaiser Hospital/Kaiser Foundation appears to have given Mr. Hammond incorrect or incomplete information, for Mr. Hammond's April 23, 1973 letter to Mr. Kane was corrected in a letter to Mr. Kane dated May 1, 1973, which said in part:

> "Our letter of April 23, 1973, was in error.

"The Kaiser Foundation does accept welfare clients as hospital patients who are not OEO/Welfare eligible. This statement is substantiated by a call from Mr. Sam Hufford, Regional Manager for the Kaiser Foundation and our payment records. Substantial payments were made during the later part of April 1973, for non-OEO hospital patients.

"We are sorry that our letter of April 23 as in error [sic], the result of an erroneous conclusion *being drawn from misinformation.*" (emphasis supplied)

4. Exhibit A to this affidavit is a copy of a letter to your affiant dated May 17, 1973, signed by Mr. Hammond, of the Public Welfare Division. Exhibit A states:

"We are enclosing the Kaiser Foundation's hospital and drug billings requested in your letter of May 13, 1973. All identifying information has been removed from these invoices. The remaining detail is public information."

5. The Bess Kaiser Hospital billing summaries forwarded by Mr. Hammond with his May 17, 1973 letter, exhibits B through E to this affidavit, disclose that Bess Kaiser Hospital/Kaiser Foundation Hospitals charges the Public Welfare Division substantially more for drugs than the maximum figure contained in the Oregon Public Welfare Division's Pharmaceutical Services Guide for Public Welfare Medical Assistance, Appendix 1 to my Rule 56 affidavit executed April 9, 1973, and negatives defendants' unsupported contention that Kaiser is "nonprofit."

6. Your affiant and other community pharmacists are required to comply with the state's Pharmaceutical Services Guide, and are audited by the state and federal government to insure compliance. However, exhibits B through E to this affidavit disclose that Kaiser does *not* comply with the state's Pharmaceutical Services Guide, although the Guide is binding on Kaiser and other hospitals.

7. Exhibit B to this affidavit, hospital billing summary RL 2257, discloses that Kaiser charged the Public Welfare Division *$15.75* for 45 Ampicillin capsules. The maximum charge, according to the Guide, is *$9.35* for 50 capsules.

8. Exhibit C to this affidavit, hospital billing summary TV 8179, discloses that Kaiser charged the Public Welfare Division $18 for six Benadryl injections, available to the community pharmacy at $3.60. The maximum charge, according to the Guide, is *$6.25*, or about one-third of the Kaiser charge.

9. Exhibit D to this affidavit, hospital billing summary TP 3897, discloses that Kaiser charged the Public Welfare Division *$164* for 41 cc. of Talwin. The maximum charge, according to the Guide, is *$19.06*, or *one-eighth* the sum charged by Kaiser.

10. Exhibit E to this affidavit, hospital billing summary NF 8814,

[R. 811]

discloses that Kaiser charged the Public Welfare Division *$52* for 13 doses of Klor Vess, a routine potassium and chloride supplement the Guide does *not* authorize for reimbursement, and *$2.10* for *six* Coumadin tablets. The maximum charge, according to the Guide, is *$1.80* for *12* Coumadin tablets.

(Subscription, jurat and certificate of service omitted in printing)

[R. 830]

United States District Court for the District of Oregon

PLAINTIFF'S OBJECTION TO HOSPITAL WITNESS "ESTIMATES" OF "WALK-IN" DRUG SALES TO MEMBERS OF PUBLIC, AND BRIEF IN SUPPORT OF MOTION

(Filed May 23, 1973; caption omitted in printing)

Pursuant to prior orders of the Court and Rule 56, F.R.Civ.P., plaintiff objects, for purposes of the Court's consideration of defendants' motion for summary judgment on plaintiff's Second Cause of Action, to all testimony by witnesses deposed to date by the parties and deposition exhibits pertaining in whole or in part to "estimates" of hospital sales of prescription drugs to "walk-in" members of the public on the following grounds:

(1) the "estimates" lack foundation;

(2) the "estimates" are contrary to the evidence;

(3) the "estimates" are irrelevant because the existence of such sales, not their extent, is material.

DATED: May 23, 1973.

(Subscription omitted in printing)

[R. 831]

BRIEF IN SUPPORT OF OBJECTION

Defendants' memoranda in support of their summary judgment motion attempt to minimize "walk-in" and other nonpatient drug sales by the 14 alleged "nonprofit" hospitals.

Defendants do so by misplaced reliance on self-serving "estimates" given without proper foundation by hostile hospital witnesses adverse to the plaintiff and its cause of action.

Defendants refer to the testimony objected to by plaintiff in Appendix 2 to defendants' opening memorandum and at page 6, lines 1-11, of their reply memorandum.

The extent of the sales, assuming but not conceding that they are as infrequent as some of the witnesses estimated, is irrelevant. What is relevant is that they took place.

Mr. Terry G. Mack, Administrator of the Gresham Community Hospital, testified at his December 20, 1972, deposition:

> "Q Are members of the general public allowed to purchase drugs from the hospital pharmacy?
> "A *We have no policy prohibiting such; therefore, my answer would be yes.*" (Mack dep. p. 10, lines 11-14) (emphasis supplied)

And the Raymond L. Montee affidavit filed on February 5, 1973 contains uncontradicted evidence

that he was not discouraged when he attempted to, *and succeeded* in his attempts to purchase prescription drugs as a member of the general "walk-in" public from the following "nonprofit" hospitals:

Kaiser Foundation Hospital Pharmacy
St. Vincent Hospital and Medical Center Pharmacy
Dwyer Memorial Hospital Pharmacy
Gresham Community Hospital Pharmacy
Holladay Park Hospital Pharmacy
Portland Adventist Hospital Pharmacy
Willamette Falls Community Hospital Pharmacy
Willamette Methodist Convalescent Center
Woodland Park Hospital Pharmacy

[R. 832]

The various "estimates" given by the hospital witnesses and relied on by defendants in their memoranda are highly objectionable because the estimates were given without a proper foundation. A proper foundation, for example, would have been an analysis of a statistically valid portion of the hospital prescription records for a stated period of time, actual identification of each "walk-in" prescription drug sale during the period, followed by extrapolation to arrive at a valid estimate.

Instead, the "estimates" appear to have been derived without any reference to actual "walk-in" sales and with the purpose of attempting to minimize such sales.

The various estimates are basically objectionable when they are flatly contrary to the record.

Defendants claim, for example, that the estimated number of "walk-in" drug sales by Emanuel Hospital is 12 or 15 per month. That "estimate" appears to fly in the face of the drug containers issued by Emanuel Hospital and filed with the Clerk of the Court on May 18, 1973, with the third Rule 56 affidavit of Stanley Hartman. Mr. Hartman's affidavit said at page 3, lines 26-29:

> "7. Between December 26, 1967, when it issued prescription number 335096, and May 8, 1973, when it issued prescription number 546054, Emanuel Hospital issued *216,958 new prescriptions* [sic], plus a substantial but undetermined number of prescription refills." (emphasis in affidavit)

Defendants' claim that St. Vincent Hospital issued only "1 or 2" walk-in prescription sales per month is less than persuasive when the number of St. Vincent Hospital nonpatient prescription containers on file with the Clerk of the Court are considered. As stated at page 4, lines 15-17, of the third Rule 56 affidavit of Stanley Hartman:

> "10. Exhibit A to this affidavit also discloses that St. Vincent Hospital issued *38,045 new prescriptions* between March 15, 1971 and March 9, 1973, a two-year period." (emphasis supplied)

Assuming, but not conceding, that the relatively small numbers in the "estimates" are relevant to the summary judgment motion, defendants have failed to meet their burden of proof that the "estimates" constitute admissible evidence. On their face the "estimates" appear to have been pulled out of thin air by interested witnesses hostile to plaintiff.

In this context it is significant that various of the law firms representing defendants herein also represent various of the hospitals whose officials were deposed by the parties. The relationship should have enabled those law firms to benefit from their "inside" knowledge of their hospital clients in terms of obtaining the maximum amount of evidence favorable to defendants herein.

Although they had ample opportunity to do so on cross-examination, defendants failed to produce admissible evidence that the "walk-in" sales to the general public were as small, e.g., "1 or 2" per month, as defendants claim in their memoranda.

Plaintiffs affidavits challenge the accuracy of deposition testimony "estimates" and those affidavits remain uncontradicted as of the date of this memorandum.

Although Rule 56 summary judgment motions contemplate the use of affidavits, the defendants have not seen fit to file any personal knowledge affidavits concerning any of the issues of fact raised by plaintiff's

affidavits and other portions of the trial court file.

* * * * *

(Subscription and certificate of service omitted in printing)

ORAL OPINION OF THE DISTRICT COURT, MAY 25, 1973

(Transcript filed October 4, 1973)

[Tr. 1]

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Plaintiff,

vs.

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, et al.,

Defendants.

Civil No. 71-543

Portland, Oregon

May 25, 1973

TRANSCRIPT OF PROCEEDINGS

BEFORE:

The Honorable James H. Burns, United States District Court Judge.

(Appearances omitted in printing)

[Tr. 88]

* * * * *

THE COURT: * * *

Despite the suggestion by Mr. Kane that I should make written detailed findings, I do not do so. I cannot; if I took the time to give a written opinion, it would be far beyond the two-month period which Mr. Tilbury mentioned in his letter and my decision would be the same at the end of that time. The grammar would be better, but I intend to rule upon this from the bench at this time.

[Tr. 89]

What is presented, of course, is a question of statutory construction, and I am frequently reminded when I get into statutory construction cases of the statement which Justice Frankfurter made in *Greenwood versus the United States*. In case anybody's interested in the citation, 350 US at 374, who said, I guess with tongue in cheek, "This is a case for applying the canon of construction of the wag who said when the legislative history is doubtful, go to the statute."

I think that's what I'm required to do here, although also ran across a rather intriguing remark made by Justice Holman in the products liability decision that just came out *Markel* (phonetic) *versus Mul How* (phonetic), 196 Oregon Advance Sheet 1739. He said, "In the final analysis, it is the intention of the legislator that governs the lack of legislative history on this particular point indicates that in all probability the legislature never considered the matter which is true of most statutory construction problems or else they would not exist." And I'm called upon to construe the statute here. However, before I indicate to you what my ruling will be, I'm going to respond to the motion to strike portions of the affidavits which have been submitted by plaintiff, and as I read the cases which Mr. Wright's memo, I believe it was Mr. Wright's memo, talks about, he contends that the moving party in a summary judgment motion not only has the right but indeed the duty to move to strike affidavits which it believes are inappropriate in whole or in part, and then there are in effect the equivalent, because by the plaintiff's objection to the so-called statements by witnesses, deposition witnesses, I suppose is sort of the equivalent of that, but again if I were to rule with the detail that Mr. Kane requested on this motion, not only would it take more than two months, it would probably take about two years.

[Tr. 90]

I'd like to just quote from certain affidavits which have been submitted in this case. First from Mr. Tilbury's affidavit filed March 21, 1973 in Paragraph 14 of the affidavit there is a quotation from what Mr. Tilbury swears is the March 21, 1973 Wall Street Journal in which reference is made to a certain SEC proceeding in which apparently Kaiser agreed to the Federal Court injunction which arose from a case in which the SEC brought charges of securities fraud against Kaiser. Kaiser apparently entered into what I

understand would be the equivalent of a consent decree, but the article goes on to say, "Kaiser agreed to a Federal Court injunction without admitting its guilt, without admitting or denying guilt, but the matter still isn't closed. The Royal Canadian Mounted Police are continuing a criminal investigation in a possible violation of British Columbia Securities law."

In Mr. Kane's March 20 affdavit, which is 45 pages and contains a number of attachments by way of exhibits, Exhibit B5 is — well, excuse me, Exhibits B2 through B6, B1 through B6, is a photo copy of the cover of Rampart's Magazine for November, 1970 together with the pages of an article about Kaiser. The article apparently is entitled "Kaiser and the Health Business."

This is a four-page article, and the justification for the affixing of this article to the affidavit appears on Page 43 of the affidavit. The statement is made, "Additional authoritative indicia that the quality or lack of quality in Kaiser medical and drug care is a disputed issue, is Exhibit B to this affidavit. Exhibit before it made a part of the trial court file by this reference is a copy of the covering article by Judith Milgrom

Carnoy titled, "Kaiser: You Pay Your Money and Take Your Chances," published in Rampart's [sic] Magazine November, 1970.

It is sufficient for me to say that to whatever extent that material in the affidavits which have been submitted is relevant, I have taken it into account. To the extent that it is irrelevant, I have not taken it into account, and if that is [not] an adequate finding, I'm sure that there will be appellate advice to that effect forthcoming.

With respect to the defendants—excuse me—with respect to the plaintiff's objection to the so-called estimates, that objection will be treated as overruled.

We come, then, to the central issue in this case which is whether or not the defendants' motion for summary judgment should be granted, and I have no hesitation in saying that I believe that it should and I intend to grant it for the reasons I will indicate briefly.

The vast majority of the drugs which are purchased here and which are used by the hospitals are for the use of the hospital clearly within the meaning of Section 13(c), whether that percentage be 85 or 90 or 95 is of no moment because

even Mr. Kane agrees that the truly in-patient that is the hospitalized bed patient and for practical purposes, the person who receives treatment in the emergency ward, receives the type of treatment for which the section was intended.

This leaves us with the other categories which have been mentioned, and I will simply summarize them. With respect to out-patient treatment whether it be initial or repeated out-patient treatment, I do not believe that it was the Congressional purpose to render inapplicable the statute merely because there was a change in the distribution of health care wherein the degree of out-patient treatment increased over the years since the '30's when this statute was passed.

With respect to the take-home drugs, that is by those who are issued prescriptions by doctors at the time that they are discharged from the hospital where they have normally been in-patient or bed patient, it seems clear to me that that also falls within the clear meaning of the applicability of the statute and that such drugs are indeed for the use of the hospital and thus qualify for the exemption.

With respect to the furnishing of

drugs to employees and staff physicians and other members of the staff, I have some mild degree of question, but not sufficient in my mind, to justify denying the motion for summary judgment. I think this may fairly be said to be for the use of the hospital.

With respect to the walk-in patients, I am persuaded by *Logan Lanes* that even though it might be said that those are not for the use of the hospital, nonetheless, the fact that walk-in sales exist in the amounts indicated by this record would not justify withdrawing from the hospitals the exemption of 13(c).

Furthermore, the fact that there is a dispute apparently as to the exact number of walk-in sales or the exact dollar amount of walk-in sales, would not in my judgment amount to a genuine issue of material facts sufficient to justify denial of the motion for summary judgment.

In short, I believe under *Logan Lanes*, the conduct and the pattern established here by this record is such that the Ninth Circuit would, in fact, conclude that a motion for summary judgment should be granted as to the second cause of action because I believe that the Ninth Circuit would agree with me

that there is no genuine issue of material fact in the second cause of action.

Furthermore, even though I have a little more difficulty in my mind with the Kaiser situation than with the so-called fee for service or so-called non-profit hospitals, that is Emanuel, St. Vincent and the others which have been mentioned, nonetheless, I conclude that it is fairly within the Congressional purpose in that the establishment of satellite pharmacies and satellite clinics throughout the area is not so divorced either conceptually or substantially from the purposes and functions of a hospital, the central hospital institution itself.

I conclude it's not so divorced as to justify withholding from that organization benefits of Section 13(c).

As I say, I have some — I am not as sure in my own mind with respect to the Kaiser situation as I am with respect to the other hospitals which have been mentioned, but if, in fact, there is a policy judgment to be made analyzing and studying the policy that Congress had in mind and how it can best be effectuated at this point in time, 35 years after it's enacted, the Ninth Circuit is a far better able Court and group and body to elaborate

policy and if, in fact, the Kaiser type of plan which as Mr. Clarke has said and as indeed Mr. Kane has agreed is the emerging form, whether or not that takes such a form as to have significant effects on persons such as plaintiff assignors and if, in fact, the action of this Court is destructive of what Congress' policy is or ought to be, then I think that is a policy decision for the Ninth Circuit to make.

I do not believe I am doing a disservice to the Congressional policy by rendering this decision in this fashion.

Learned Hand — at one time, I think it was Learned Hand, spoke of the art of statutory construction as being the proliferation of purpose and necessarily, when a single District Judge in Portland, Oregon sits and tries to proliferate the Congressional purpose of three-and-a-half decades ago, one must approach the task with some degree of diffidence and hesitation. I've given it the best study I can, Gentlemen, and I believe that this decision is consonant with and not in contradiction to the Congressional purpose of enacting 13(c) and so for the reasons I have indicated and bearing in mind that I'm sure my learned brethren

on the Ninth Circuit will forgive the atrocity of my grammar, I grant the motion.

Furthermore, on the assumption that Mr. Kane would move as he did in connection with the earlier ruling of this Court, I am prepared to discuss Section 1292 Sub-B. Do you so move, Mr. Kane?

(Whereupon a brief off-the-record discussion was had.)

MR. KANE: All right, Your Honor, we would be happy to have the Court certify this for an interlocutory appeal, although we are not very happy with the state of the record.

THE COURT: And do you renew the motion which you made last fall at the time I ruled on Causes of Action No. 3 and 4 for a similar certification?

MR. KANE: Yes, we do, Your Honor.

THE COURT: All right. Do you gentlemen desire to be heard in opposition to that motion — Mr. Clarke?

MR. CLARKE: No desire to be heard, Your Honor.

THE COURT: I'm satisfied that this order as well as the corresponding orders issued last fall concerning Count III and Count IV involve

together a controlling question of law as to which there is a substantial ground for difference of opinion and I am furthermore of the opinion strongly that an immediate appeal from this order and the one last fall disposing of Counts III and IV may materially advance the ultimate termination of litigation.

I will so state in writing pursuant to the provisions of 28 USC, 1292, Subsection B when you present such an order and I would assume, Mr. Clarke, that you will follow the issue of policy that we established some time ago.

You should prepare an order, check it with Mr. Kane and be prepared to present it to me in such fashion that you can assure the Court that there is no objection as to form.

MR. CLARKE: Your Honor, one detail. The order last fall on the 3rd and 4th causes of action, there was never a written order entered on it.

THE COURT: Then I would simply incorporate into this order that I do not recall whether that was a motion for summary judgment or —

MR. CLARKE: Well, it was a motion to dismiss.

THE COURT: It was a motion to dismiss.

[Tr. 99]

I see no reason why we shouldn't put all three into this one order, along with the appropriate language from 1292B and then that will complete the matter.

MR. CLARKE: Thank you.

(Reporter's certificate omitted in printing)

[R. 868]

ORDER AND PARTIAL SUMMARY JUDGMENT

(Filed June 22, 1973)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon nonprofit corporation, on behalf of its assignors,

Plaintiff,

vs.

ABBOTT LABORATORIES, et al.,

Defendants.

Civil No. 71-543

ORDER AND PARTIAL SUMMARY JUDGMENT

Defendants' motion for an order pursuant to Rule 12 (b) (6), Federal Rules of Civil Procedure, dismissing the third and fourth causes of action of plaintiff's Amended Complaint, came on for hearing before the Court on September 11, 1972, and the Court granted defendants' motion on the ground that the third and fourth causes of action do not state claims upon which relief can be granted.

Defendants' motion pursuant to Rule 56 (b), Federal Rules of Civil Procedure, for summary judgment in their favor on the second cause of action of plaintiff's Amended Complaint, came on for hearing before the Court on May 25, 1973, and the Court granted defendants' motion for the reason that the transactions referred to in the second cause of action are exempt from the Robinson-Patman Act under 15 USC § 13c, there is no genuine issue as to any material fact respecting such exemption and defendants are entitled to judgment on said cause of action as a matter of law.

[Tr. 869]

NOW, THEREFORE, IT IS ORDERED AND ADJUDGED AS FOLLOWS:

1. The third and fourth causes of action of the Amended Complaint are dismissed for failure to state claims upon which relief can be granted.

2. Summary judgment is hereby entered in favor of defendants on the second cause of action of the Amended Complaint.

3. This Court is of the opinion that this order involves controlling questions of law as tc which there is substantial ground for difference of opinion, and that an immediate appeal from this order may materially advance the ultimate termination of the litigation.

Dated this 22 day of June, 1973.

(Subscription omitted in printing)

[R. 871]

United States District Court for the District of Oregon

AFFIDAVIT OF HENRY KANE RE WILLIAM H. RORER, INC. "IN-HOSPITAL USE ONLY" DRUG CONTAINER AND NOTICE OF DEPOSIT OF SAID EXHIBIT WITH THE CLERK OF THE COURT

(Filed July 31, 1973; caption omitted in printing)

STATE OF OREGON)
) ss.
County of Multnomah)

I, Henry Kane, being first duly sworn, depose and say:

I

I am one of the attorneys for the plaintiff in the above-titled cause, am familiar with the files, and make this affidavit to identify an exhibit deposited with the Clerk of the Court on July 31, 1973.

II

Defendant William H. Rorer, Inc. is the manufacturer of a suspension antacid identified by the trademark "CAMALOX" and National Drug Code number NDC 67-180-64, and distributed in a six fluid ounce glass container with a bottle cap bearing the identification "RORER."

III

Exhibit A to this affidavit is a photocopy of an empty container of "CAMALOX" plus a bottle cap bearing the name "RORER" and a pharmacy label reading as follows:

[R. 872]

"WOODLAND PARK HOSPITAL PHARMACY
10300 N. E. Hancock Portland, Ore.
Phone 255-1313 AW 1636046
"No. 64317 Dr. Freiermuth
Eleanor Campbell
Take one teaspoonful every
two hours.
6 20 73h SHAKE WELL
Camalox suspension"

IV

The printed label of the manufacturer, defendant Wiliam H. Rorer, Inc., contains the following printed restriction:

"THIS PACKAGE FOR
IN-HOSPITAL USE ONLY"

V

The above-quoted restriction is evidence of the fact that defendant William H. Rorer, Inc., recognizes that drugs sold to hospitals at prices, terms and conditions not made available to community pharmacies must be consumed *in* the hospital by a hospital patient.

VI

However, Exhibit A confirms that the drug manufactured by defendant William H. Rorer, Inc. was sold for use *outside* the hospital despite the printed restriction quoted in paragraph IV of this affidavit.

VII

On July 31, 1973, I deposited with the Clerk of the Court a sealed cardboard container containing the glass container identified in paragraphs I, III, and IV of this affidavit.

(Subscription, jurat and certificate of service omitted in printing)

[R. 891]

United States District Court for the District of Oregon

PATRICIA NEUBERGER AFFIDAVIT RE EMANUEL HOSPITAL DRUG PRESCRIPTION

(Filed September 4, 1973; caption omitted in printing)

STATE OF OREGON)
) ss.
County of Washington)

I, PATRICIA NEUBERGER, being first duly sworn, depose and say:

1. I am a pharmacist licensed by the State of Oregon, the manager of Riggs Pharmacy, located at 1049 Lloyd Center, Portland, Oregon, and make this affidavit in opposition to defendants' motion for summary judgment on plaintiff's Second Cause of Action.

2. On August 27, 1973, I was on duty in the Riggs Pharmacy when a person identified as Christine Harder presented for refill a prescription issued by Emanuel Hospital in May of 1973, prescription number 545-948 for Ovulen 21, a birth control prescription. The container disclosed that the prescription was for a three-month period.

3. The Emanuel Hospital prescription label disclosed that the price for the Emanuel Hospital prescription for a three-month supply of Ovulen 21 was $4.50.

[R. 892]

4. When I informed her that the charge for a three-month refill would be $6.75, or $2.25 more than the Emanuel Hospital charge, the prospective purchaser said she would not order the prescription, but would obtain the prescription at a later date.

5. The charge of $6.75 for a three-month cycle is the usual and customary charge at the Riggs Pharmacy and is but slightly higher than the ceiling price of $6.40 set by the State Public Welfare Division in its Pharmaceutical Services Guide for Public Welfare Medical Assistance Programs, as reissued December 1, 1970.

6. Based on my experience as a community pharmacist, it is my considered belief that the only reason the purchaser cancelled her order for a refill was that our price was higher than the price charged by Emanuel Hospital.

7. The prescription presented to me had a prescription number and therefore was not a hospital drug order for a hospitalized inpatient.

DATED: August 28, 1973.

(Subscription, jurat and certificate of service omitted in printing)

[R. 894]

United States District Court for the District of Oregon

STANLEY HARTMAN AFFIDAVIT RE DIVERSION OF DRUG

(Filed September 4, 1973; caption omitted in printing)

STATE OF OREGON)
)ss.
County of Washington)

I, STANLEY HARTMAN, being first duly sworn, depose and say:

1. I am a pharmacist licensed by the State of Oregon, an officer of one of plaintiff's assignors, am familiar with the records of this case, make this affidavit on my personal knowledge, and make this affidavit in opposition to defendants' motion for summary judgment on the Second Cause of Action of plaintiff's amended complaint.

2. There has come into my possession a Permanente Services Pharmacy drug container label attached to a bottle bearing a label identifying the manufacturer as defendant Carter-Wallace, Inc. The manufacturer's label states that the bottle contains 100 coated tablets of Miltown (meprobamate) 200 mg. and that the manufacturer is the Wallace Pharmaceuticals Division of Carter, Wallace, [sic] Inc., Cranbury, New Jersey. An identification number on the manufacturer's label is LB-18-3-10.

[R. 895]

3. In the center of the manufacturer's label is a three-fourth inch high letter "H" printed in red.

4. I know of my own personal knowledge that the letter "H" printed on said manufacturer's label means that Carter-Wallace, Inc. has specified that the drug must be used only in the hospital and nowhere else. It is, in effect, an identification that the drug is a "hospital use only" drug.

5. However, the bottle contains a prescription label as follows:

"KEEP OUT OF REACH OF CHILDREN
"SE 94047 DeMond
"ARTHUR CHASE
"one 3 times a day
"5 31 66 H
"Meprobamate 200mg
"PERMANENTE SERVICES PHARMACY
"7705 S. E. Div., PR 7-3311, Portland, Ore., #1211"

6. The prescription label is evidence that despite the restriction printed on the manufacturer's label signifying that the drug was limited to consumption within a hospital, the drug was issued as a prescription which, by definition, excludes hospital consumption. Such use constitutes diversion in violation of the 15 U.S.C. § 13c exemption.

7. The manufacturer's symbol "H" is evidence of defendant Carter-Wallace, Inc.'s recognition that such drugs sold to hospitals at preferential prices not avail-

able to community pharmacies must be used within the hospital.

(Subscription, jurat and certificate of service omitted in printing)

[R. 897]

United States District Court for the District of Oregon

FIFTH RULE 56 AFFIDAVIT OF STANLEY HARTMAN IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THE SECOND CAUSE OF ACTION, RE EVIDENCE OF DRUG SALES TO NON-HOSPITALIZED PURCHASERS, AND NOTICE OF DEPOSIT OF PRESCRIPTION DRUG CONTAINERS EXHIBIT WITH CLERK OF THE COURT

(Filed September 10, 1973; caption omitted in printing)

TO: DEFENDANTS AND THEIR LOCAL COUNSEL OF RECORD:

Please take notice that plaintiff on September 10, 1973, deposited with the Clerk of the Court the prescription drug containers identified in Exhibit A to the fifth Rule 56 affidavit of Stanley Hartman attached to this notice.

(Subscription omitted in printing)

[R. 898]

AFFIDAVIT OF STANLEY HARTMAN

STATE OF OREGON)
)ss.
County of Washington)

I, STANLEY HARTMAN, being first duly sworn, depose and say:

1. I am a registered pharmacist licensed by the State of Oregon, am engaged in the practice of pharmacy as a community pharmacist, am a member of plaintiff, Portland Retail Druggists Association, Inc., am an officer of one of the assignors herein, am familiar with the prescription drug containers issued by the pharmacies of the various hospitals whose chief pharmacists and other officials were deposed by plaintiff, am competent to make this affidavit concerning the matters stated herein, make this affidavit on my own personal knowledge, and make this affidavit pursuant to Rule 56(e) of the Federal Rules of Civil Procedure and pursuant to the desire of the Court for "numbers" concerning drug practices of alleged "nonprofit" hospitals, and in opposition to defendants' motion for summary judgment on plaintiff's Second Cause of Action.

2. I certify that Exhibit A to this affidavit is a full, true and accurate representation of the data contained on 101 prescription drug containers received by your affiant and other pharmacists in the regular course of business from persons to whom the contain-

ers and their contents were issued by the hospital and clinic pharmacies listed in Exhibit A hereto. Hospital drug orders, representing drugs issued to hospitalized "inpatients" are *not* listed in Exhibit A to this affidavit. The prescription drug containers listed in Exhibit A each bear a prescription number issued by the pharmacy pursuant to state and federal law, hence the prescriptions were issued to non-hospitalized purchasers.

3. Exhibit A and the prescription drug containers identified in said exhibit are submitted to the Court as additional and physical evidence of drug sales to non-hospitalized purchasers by various alleged "nonprofit" hospitals outside of the 15 U.S.C. § 13c exemption.

[R. 899]

4. A significant number of the prescription drug containers listed in Exhibit A to this affidavit are dated subsequent to the forced termination of plaintiff's limited discovery as to the drug distribution practices of the various alleged "nonprofit" hospitals, e.g., drug sales as recent as recent [sic] as July 17, 1973.

5. Exhibit A to this affidavit lists prescription drug containers issued by the pharmacies of the following hospitals:

(a) Emanuel Hospital (pp. 5-7);

(b) St. Vincent Hospital and Medical Center (pp. 7-10);

(c) Holladay Park Hospital (pp. 10 and 13);

(d) Providence Hospital (pp. 10-11);

(e) Portland Adventist Hospital (pp. 12-13);

(f) Good Samaritan Hospital and Medical Center (pp. 13-14);

(g) Kaiser Foundation Hospital and related clinic pharmacies (pp. 15-17).

6. Analysis of the prescription drug numbers on the containers listed in Exhibit A to this affidavit establishes that each of the above-listed "nonprofit" hospitals issued a substantial number of prescription drugs to non-hospitalized purchasers.

7. Between August 26, 1971, when it issued prescription number 476,766, and July 16, 1973, when it issued prescription number 553,144, a period of some 23 months, Emanuel Hospital issued *76,378 new prescriptions*, plus a substantial but undetermined number of refills.

8. Between August 30, 1971, when it issued prescription number 146,135, and May 22, 1973, when it issued prescription number 172,377, a period of less than two years, St. Vincent Hospital issued *26,242* new prescriptions, plus a substantial but undetermined number of prescription refills.

9. Between August 11, 1970, when it issued prescription number 83,132, and May 31, 1973, when it issued prescription number 109,176, Holladay Park Hospital issued *26,044 new prescriptions* during a period of less than two years.

[R. 900]

10. Exhibit A to this affidavit also discloses that Providence Hospital issued *22,432 new prescriptions* between April 8, 1971 and June 18, 1973.

11. Exhibit A to this affidavit also discloses that Portland Adventist Hospital issued *19,982 new prescriptions* between November 9, 1971 and May 30, 1973.

12. Exhibit A to this affidavit also discloses that Good Samaritan Hospital issued *11,089 new prescriptions* in one year—May 11, 1972 to May 15, 1973.

13. Exhibit A to this affidavit also discloses that the Bess Kaiser Hospital issued *124,575* new prescriptions in less than two years—September 26, 1971 to June 16, 1973, plus a substantial number of prescriptions issued by its affiliated "Permanente Services" pharmacies.

14. Exhibit A to this affidavit, however, does *not* reflect sales to physicians by the hospitals for the office use of the physicians.

(Subscription, jurat and certificate of service omitted in printing)

OPINION OF THE COURT OF APPEALS

(Filed December 26, 1974)

[C.A. Op. 1]

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors and all others similarly situated in the State of Oregon,

Plaintiff-Appellant,

vs.

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation, and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Defendants-Appellees.

No. 73-2342

OPINION

On Appeal from the United States District Court
for the District of Oregon

Before: MERRILL and WALLACE, Circuit Judges,
and POWELL, District Judge*

MERRILL, Circuit Judge:

Plaintiff-appellant commenced this action as the assignee of the antitrust claims of more than sixty retail pharmacies engaged in business in the Greater Portland, Oregon, area. Suit was brought against twelve manufacturers of prescription drugs and sought injunctive relief and damages. Appellant's complaint was stated in

* Honorable Charles L. Powell, Senior United States District Judge for the Eastern District of Washington, sitting by designation.

[C.A. Op. 2]

five claims, only the second of which is involved in this appeal.[1] That claim charges that defendant drug manufacturers have violated the Robinson-Patman Act, 15 U.S.C. §§ 13, et seq. (1970),[2] by selling to certain hospitals[3] as prices lower than those charged to the retail pharmacies, appellant's assignors; that the favored hospitals, to some extent at least, then engaged in the resale of the drugs so sold. Defendants-appellees contend that the sales in question are exempt from operation of the Act under 15 U.S.C. § 13c (1970), which reads:

> "Nothing in section 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."

After limited discovery and submission of affidavits the district court granted summary judgment in favor of appellees on that claim. The court ruled that each of the fourteen hospitals here involved was "not operated for profit" and that the drugs had been purchased and used for each hospital's "own use." Both of these rulings are assigned as error on this appeal.

We reject appellant's contention that the hospitals did not qualify for exemption (even as to that portion of the purchases which might be "for their own use"), since none of them were "hospitals [or] charitable institutions not operated for profit." It was undisputed

that the hospitals derived substantial profits from the sale of drugs and from time to time enjoyed over-all operating surpluses. However, the existence of such profits or surpluses is not in itself enough to foreclose availability of the exemption. In an integrated medical

center it is to be expected that one department may provide financial support to another. No enterprise such as these could long remain in existence if each department consistently operated at a loss. Nor could it expect long to continue the fortuity of operating each department or the hospital as a whole precisely at the break-even point. There was no allegation that these hospitals (with the possible exception of Kaiser, *see infra*), distributed assets to any interested person, and they could not do so under the terms of their charters. The surpluses were expended in the over-all cost of continuing operations or invested for the improvement of facilities.[4] Accordingly, the district court did not err in ruling that the thirteen hospitals other than Kaiser were "not operated for profit" within the exemption. *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212, 216 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967).[5]

We believe the district court erred, however, in granting summary judgment as to sales made to Bess Kaiser Hospital. The effect of this hospital's operation as an element of an organization providing comprehensive health services to members for a predetermined fee, and the possibility that some of its physicians, partners in the Permanente Clinic, receive distributions based on net revenues of the Kaiser Foundation Health Plan (to which revenues from drug sales may contribute), appear to present disputed issues of fact which may be material to the hospital's nonprofit status under the exemption. Moreover, in our judgment the proper legal standard for determining whether Bess Kaiser Hospital is "not operated for profit" in these circumstances cannot be developed on the limited record before us. Since we remand the

cause for further proceedings, this issue can more fully be explored below.

The remaining issue is whether purchase of drugs for resale were purchases by the hospitals "for their own use" as that phrase is used in § 13c. With disputed issues of fact resolved in favor of appellant for purposes of the motion for summary judgment, it appears that drugs were distributed by the hospitals under the following circumstances:

1. They were dispensed to the hospital's inpatients in the course of treatment.

2. They were dispensed in the course of treatment to patients at emergency clinics operated by the hospitals.

3. They were provided to departing in-patients as take-home prescriptions.

4. They were provided to persons who had been in-patients as renewals of prescriptions which had first been filled while those persons were in-patients.

5. They were sold for home treatment to out-patients either at hospital pharmacies or at out-patient clinics.

6. They were sold to the hospitals' employees and students for the private use of purchasers.

7. They were sold to hospitals' physicians for their personal or family use or for dispensation in the course of their private practice.

8. They were sold to walk-in customers who were not hospital patients.

The circumstances covered by categories 1 and 2, relating to in-patient and emergency treatment, cover by far the greater part of hospital distribution. There is

no dispute that such dispensing of drugs in the course of treatment in the hospital is the hospitals' own use. It is as to distribution under other circumstances that the parties are in dispute, both factually, and to the frequency of occurrence, and legally, as to whether those uses of the drugs can properly be regarded as the hospitals' own use.

Appellees justify the uses thus made by the hospitals as proper hospital functions. It is asserted that the need of the departing in-patient for take-home

drugs is obvious, and that supplying this need is an essential hospital function; that sales to former patients are in connection with hospital or clinic treatment earlier provided and permit such treatment to continue at home; that sale to employees is pursuant to collective bargaining agreements; that sales to students are an aspect of the hospitals' educational programs; that sales to physicians associated with the hospitals are a perquisite of that association; that sale to walk-in customers is limited to instances when needed drugs cannot be obtained elsewhere; that in all respects a decent regard for the needs of the community and the position of the hospital as a center for the provision of a full range of health services justifies all use made by the hospitals of the drugs sold to them.

We may concede that in these respects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospital's "own use." Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of in-patients

or emergency patients. The purpose for which these supplies are purchased — the use to which they are to be put — is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer.

The hospitals here are (quite properly) accommodating patients, staff and strangers with means whereby they can conveniently purchase for *their* use. The question is not whether the hospitals can continue to provide this useful community service. The question is whether in providing it they may acquire the drugs for such resale at an acquisition price that discriminates against local retail druggists. We hold that they may not.

Logan Lanes, Inc. v. *Brunswick Corp.*, *supra*, does not require the contrary result. There the alleged discriminatory pricing was for bowling alley equipment sold to a state university. The lanes had been acquired for use in connection with the university's physical education program and for recreational use of faculty, staff and students and were operated for those purposes. They were not, however, closed to the general public and some public use (the extent was disputed) was made of them. We held:

> "The primary purpose of the purchases established beyond dispute, was to fulfill the needs of the University in providing bowling facilities for its students, faculty and staff. This being the case, any additional use of the bowling facilities by the general public for a fee, even if such use is substantial, would not establish that the purchases were not made for the use of the University."

378 F.2d at 216. The university's public use was indeed in competition with other local alleys, and it may be questioned whether the university should not, in all fairness, have been compelled to choose between the public use and the favorable exemption. But that is not what the statute requires. It requires only that the "supplies" be acquired by the university for its own use. It does not say that once acquired and put to that use they cannot then be used for any other purpose.

Our case does not involve the acquisition of plant equipment. It involves acquisition of stores of supplies. Plant equipment acquired for a university's own use cannot be segregated from that acquired for use by others, since the same equipment serves both uses. In the case of stores of supplies acquired for consumption the situation is otherwise. Supplies that are resold can readily be segregated from those devoted to a hospital's own use.

In this respect our case is similar to *Students Book Co.* v. *Washington Law Book Co.*, 232 F.2d 49, 50-51 n. 5 (D.C. Cir. 1955), *cert. denied*, 350 U.S. 988 (1956), where the 13c issue was disposed of in a footnote. The plaintiff, a retail seller of law books, complained of the defendant's sales at lower prices of

books to campus bookstores at law schools. The distinction drawn by the court was similar to the one we draw here — between sales of books to universities for their own use, *i.e.*, for their libraries, and sales to university connected bookstores for resale to students.

Our holding makes it unnecessary for us to deal with the remaining assignment of error.

The judgment is vacated and the cause remanded for further proceedings.

[C.A. Op. Fn. 1]

FOOTNOTES

1. *(Page 2)* The district court granted summary judgment on this claim and noted a controlling question; we accepted the interlocutory appeal under 28 U.S.C. § 1292(b).

2. *(Page 2)* Section 13(a) makes it "unlawful for any person engaged in commerce * * * to discriminate in price between different purchasers of commodities of like grade and quality * * * where such commodities are sold for use, consumption, or resale * * * and where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them * * *."

3. *(Page 2)* Appellant designates the following hospitals: Dwyer Memorial Hospital & Medical Center; Emanuel Hospital; Good Samaritan Hospital & Medical Center; Gresham Community Hospital; Holladay Park Hospital; Physicians and Surgeons Hospital; Portland Adventist Hospital; Portland Osteopathic Hospital; Providence Hospital; St. Vincent Hospital & Medical Center; Tuality Community Hospital; Willamette Falls Community Hospital; Willamette Methodist Convalescent Center; Bess Kaiser Hospital.

4. *(Page 3)* Since the exemption of appellees' sales is founded on the purchasers' status as nonprofit hospitals, we need not consider the possible relevance of the parallel exemption for "charitable institutions not operated for profit."

5. *(Page 3)* Since we limit the exemption to purchases by the hospitals "for their own use," we need not decide whether other uses to which the drugs purchased were put could be

regarded as removing drugs purchased for such other uses from the nonprofit exemption. Assuming *arguendo* that some purchases by the hospitals were put to uses outside the nonprofit exemption, the exemption as to drugs purchased for hospital uses would not necessarily be unavailable. *Cf. Young Men's Christian Ass'n* v. *Department of Revenue*, — Or. —, 522 P.2d 464 (1974).

ORDER DENYING PETITION FOR REHEARING

(Filed March 11, 1975)

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,
Plaintiff-Appellant,

vs.

ABBOTT LABORATORIES, et al.,
Defendants-Appellees.

No. 73-2342

Before: MERRILL and WALLACE, Circuit Judges and POWELL, District Judge

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for a rehearing in banc.

The full court has been advised of the suggestion for an in banc hearing, and no judge of the court has requested a vote on the suggestion for rehearing in banc. Fed.R.App.P. 35(b).

The petition for rehearing is denied and the suggestion for rehearing in banc is rejected.

The applications of American Hospital Association and Oregon Association of Hospitals to appear as amici curiae are denied.

ORDER GRANTING PETITION FOR WRIT OF CERTIORARI

(Entered June 23, 1975)

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1974

No. 74-1274

ABBOTT LABORATORIES, et al.,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., etc.,

Respondent.

The motion of American Hospital Association for leave to file a brief, as *amicus curiae*, is granted. The petition for a writ of certiorari is granted. Mr. Justice Douglas took no part in the consideration or decision of this motion and petition.

Supreme Court, U. S.
FILED
MAY 1 1975
MICHAEL RODAK, JR., CLERK

In the Supreme Court

of the United States

OCTOBER TERM, 1974

No. 74-1274

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,

Respondent,

v.

ABBOTT LABORATORIES, et al,

Petitioners.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR RESPONDENT IN OPPOSITION

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FILED
MAY 1 1975
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SUMMARY OF BRIEF

No substantial Federal question.

No conflict between circuits.

Decision is interlocutory, based on disputed, incomplete record and is therefore not ripe for appellate review.

Decision is in accord with:

(1) The only two prior appellate court decisions construing § 13c;

(2) Congressional intent in enacting Nonprofit Institutions Act of 1938;

(3) Report of 1968 House Small Business Committee, *Small business Problems in the Drug Industry;*

(4) Tax Reform Act of 1969;

(5) Internal Revenue Code § 1513-1;

(6) IRC Rev. Rul. 68-374 and 68-375;

(7) Rules of statutory construction.

Logan Lanes, relied on by petitioners, is:

(1) distinguishable on the facts;

(2) was decided by the same Court that decided the case at bar;

(3) recognizes the distinction between purchase for "own use" and purchase for resale, and

(4) is in accord with the case at bar.

Changes since 1938 in hospital drug dispensing practices do not repeal by implication the § 13c purpose to limit preferential prices to drugs dispensed to hospitalized and emergency patients.

The decision does not interfere with or have any adverse effect on hospital patients or any hospital drug function inside or outside the § 13c exemption.

Assuming *arguendo* some interference with a "non-profit" hospital's commercial drug sales in competition with community pharmacies, the § 13c exemption was never intended to allow tax-exempt organizations to engage in unfair competition with retail pharmacies.

Assuming *arguendo* the possibility of some adverse effect on non-parties, relief should be sought from the legislative, not the judicial branch of government.

In the Supreme Court

of the United States

OCTOBER TERM, 1974

No. 74-1274

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,

Respondent,

v.

ABBOTT LABORATORIES, et al,

Petitioners.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the Court of Appeals for the Ninth Circuit (App. A of Petition) is reported at 510 F.2d 486. It was an interlocutory appeal under 28 U.S.C. § 1292(b). The opinion of the District Court is reported at App. B of Petition.

JURISDICTION

The jurisdictional requisites are adequately set forth in the Petition.

QUESTION PRESENTED

Where

(a) petitioners sold drugs to 14 alleged "non-profit" hospitals in the Portland, Oregon area at prices, terms and conditions which grossly discriminated against respondent's assignors and other community pharmacies in competition with the hospitals;

(b) the hospitals resold these drugs to members of the general public having no connection with the hospitals as patients or otherwise, and also to members of their staff, the staff's families, volunteers, and to patients to use after they left the hospital;

(c) those mentioned in (b) used the drugs for their own use outside the hospitals;

(d) the hospitals resold some of the drugs to medical clinics which, in turn, resold the drugs to those mentioned in (b) at locations remote from the hospitals;

(e) the hospitals resold some of the drugs in bulk to physicians who removed the drugs to their offices where they were resold to or used by private non-hospitalized patients;

(f) the hospitals passed on their lower drug acquisition costs to employees and physicians;

(g) the hospitals did not pass on their lower drug acquisition costs to patients but, instead, reaped substantial profits of as high as 60 per cent of sales;

(h) the drug prices the hospitals charged to "walk-in" and other members of the general public and others were in many instances considerably lower than the petitioners' prices to respondent's assignors and other community pharmacies, making it impossible for the assignors and other community pharmacies to compete with the result that half of those in the Portland area have perished;

(i) the prices charged by hospitals to their hospitalized patients were frequently much higher than the prices charged to third parties for use off the premises;

are all such sales exempt from the Robinson-Patman Act, 15 U.S.C. §§ 13 et seq., by virtue of 15 U.S.C. § 13c, which provides that the Act shall not apply:

> ". . . to purchases of their supplies for their own use by . . . hospitals, and charitable institutions not operated for profit."?

RESPONDENT'S OBJECTION TO GRANTING PETITION

The petition should be denied for the following reasons:

No substantial Federal question.

No conflict between the circuits.

The decision is interlocutory, based on a disputed record and is therefore not ripe for appellate review.

The decision reflects proper application of rules of statutory construction.

The decision is in accord with Congressional intent in 1938 to limit the 15 U.S.C. § 13c, 52 Stat. 446, exemption to a non-profit hospital's ". . . purchases of their supplies for their own use." The Nonprofit Institutions Act. (App. II at A11).

Changes in the degree of hospital commercialization that have arisen since enactment of the exemption do not repeal by implication the original purpose of § 13c to limit preferential drug prices to non-commercial dispensing of drugs within the hospital to hospitalized and emergency patients.

A "non-profit" hospital's commercial drug sales at issue here in competition with retail pharmacies are outside the § 13c exemption. The decision is in accord with the findings in 1968 of a congressional committee:

> "Small Business problems in the Drug Industry," House Select Committee on Small Business, House Report No. 1983, 90th Congress, 2d Session, Dec. 31, 1968, pp. 77-83. App. I at A1. Also see R. 125-156 and R. 483-492.

The decision is in accord with the Tax Reform Act

of 1969. 83 Stat. 487, amendments to the Internal Revenue Code making hospitals and other exempt organizations subject to taxation on their unrelated commercial business income. U. S. Code Congressional and Administrative News, 91st Congress, First Session, 1969, pp. 568-573, 1689-1690, 1901-1902, 2032-2033, and 2096-2100; 26 U.S.C. §§ 501, 511, 512, and 513.

The decision is in accord with Internal Revenue Code § 1.513-1(a), Definition of unrelated trade or business, Tax Regulations, 1975, which provides in part:

> ". . . Thus, for example, the regular sale of pharmaceutical supplies to the general public by a hospital pharmacy does not lose identity as trade or business merely because the pharmacy also furnishes supplies to the hospital and patients of the hospital in accordance with its exempt purposes or in compliance with the terms of section 513(a)(2). . . ." (App. III at A18).

The decision is in accord with two Internal Revenue rulings as to when hospital drug sales constitute unrelated commercial business income. Rev. Rul. 68-374 and 68-375, Internal Revenue Bulletin, Cumulative Bulletin, 1968-2, July 1968, 242-246; R. 721-724. But see R. 724-725.

The decision is in accord with the only two prior appellate court decisions. Both decisions recognize the distinction between a § 13c "purchases of their supplies for their own use" purchase and a purchase for resale:

Students Book Company v. *Washington Law Book Co.*, 232 F.2d 49, 50-51, fn. 5 (D.C. Cir. 1955), cert. den., 350 U.S. 988 (1956).

Logan Lanes v. *Brunswick Corporation*, 378 F.2d 212, 217 (9th Cir. 1967), cert. den., 389 U.S. 898 (1967).

The decision is distinguishable on the facts from the case relied on by petitioners. See App. IV at A19.

The decision, contrary to petitioner's unsupported allegation, does not interfere with any function of a non-profit hospital, modern or otherwise.

Deliberate and repeated failure to comply with the accuracy requirement of subsection 4 of U. S. Sup. Ct. Rule 23:

> "4. The failure of a petitioner to present with accuracy, brevity and clearness whatever is essential to a ready and adequate understanding of the points requiring consideration will be a sufficient reason for denying his petition."

The facts have been grossly distorted, glossed over and misstated by petitioners.

The failures are set forth in respondent's April 13 and 18, 1975 letters to petitioners, App. V at A25.

Assuming *arguendo* some interference with a "non-profit" hospital's commercial drug sales in competition with community pharmacies, the § 13c eleemosynary institutions' exemption was never intended

to allow tax-exempt organizations to engage in unfair competition with retail pharmacies.

STATEMENT OF THE CASE

Petitioners have not asked this Court to review that portion of the decision reversing the District Court decision granting summary judgment as to drug sales made to Bess Kaiser Hospital (Pet. App. at A 4-5). Sales by Bess Kaiser Hospital to members of the general public having absolutely no connection with the hospital, either as patients or members—are massive.

The amended complaint (App. VI at A31) states that petitioners violated Section 1 of the Robinson-Patman Act, 15 U.S.C. § 13, 49 Stat. 1526, by:

1. Selling identical drugs to alleged "non-profit" hospitals at lower prices than those charged respondent's assignors (neighborhood pharmacies);
2. Selling identical drugs to alleged "non-profit" hospitals at terms and conditions not offered to said assignors;
3. Hospital resale of said drugs to physicians for their office use and others outside the scope of the 15 U.S.C. § 13c, 52 Stat. 446 ". . . purchases of their supplies for their own use . . ." exemption to the Robinson-Patman Act in competition with respondent's assignors.

Petitioners accept substantially (Tr. May 25, 1973, pp. 16-17) all of the statistical data respondent assembled in chart form.

The admitted exhibit reflects the following evidence in the record:

1. Drug sales totaling $32,792,997;
2. Net profits from drug sales of $10,155,165;
3. Net profits on drug sales as high as 60 per cent;
4. Average net profit on drug sales of 38.68 per cent for the 13 hospitals for which profit data was available;
5. Drug sales to employees, physicians, volunteers and their families at prices substantially below the prices charged patients for use outside the hospital;
6. Drug sales to physicians for their private office use;
7. Drug sales to medical clinics at locations remote from the hospital;
8. Drug sales to patients for consumption after discharge;
9. Drug sales to "walk-in" members of the general public, all for use off the premises by individuals not patients of the hospital;
10. Economic death of half the Portland area neighborhood pharmacies.

Various of the alleged "non-profit" hospitals enjoyed huge overall net profits (R. 555-598).

HOSPITAL AGREEMENTS

Three petitioners already require alleged "non-profit" hospitals not to resell drugs obtained at preferential prices to members of the nonhospitalized public, thus recognizing impliedly (at least) the correctness of the decision.

The A. H. Robins new account application (R. 530) provides:

> "It is represented that drugs purchased from A. H. Robins Company by the above named institution will be dispensed only to patients, employees or students of such institution."

The Eli Lilly and Company agreement provides:

> "THIS ACCOUNT REPRESENTS THAT IT IS A NON-PROFIT ORGANIZATION (TAX-EXEMPT HOSPITAL OR TAX-SUPPORTED INSTITUTION) & THAT PURCHASES MADE UNDER THIS AGREEMENT ARE *FOR ITS OWN USE WITHIN THE INSTITUTION AND ARE NOT FOR RESALE.*" (Fawkes Dep. Ex. 8) (Emphasis added).

The Carter-Wallace, Inc. agreement provides:

> "2. HOSPITAL agrees that goods received under this Direct Sales AGREEMENT will be for use in the operation of

> HOSPITAL and its direct clinics and branches and that no merchandise so purchased will be re-sold to retail stores, chain stores, wholesalers, or other hospitals." (Fawkes Dep. Ex. 9).

The University of Oregon Medical School abandoned plans to sell drugs to private patients of staff physicians after investigation of legal and administrative requirements. (R. 657).

Sandoz, a major drug company and a non-defendant, uses a hospital price agreement that requires the hospital on preferentially priced drugs to dispense such drugs "*exclusively within the confines of the purchasing institution. . . .*" (R. 656).

THE RECORD BELOW

The trial court record is incomplete and disputed.

Despite repeated requests the District Court refused to allow respondent to make discovery of petitioners concerning their exclusive knowledge of facts relevant to their summary judgment motion.

Discovery was "limited," as the Court of Appeals stressed (A3).

Petitioners did not submit any affidavits or exhibits to contradict respondent's numerous exhibits.

Respondent's uncontradicted exhibits raise numerous issues of fact relevant to the summary judgment motion, *e.g.*, the Montee affidavit (R. 343) proving "walk-in" drug purchases from various hospitals

whose officials said they did not sell to the public. The affidavit was admitted (R. 866).

ARGUMENT

The antitrust laws, and the Robinson-Patman Act in particular, are construed broadly, while exemptions are construed strictly and in favor of competition. *Federal Maritime Commission* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973) and *Perkins* v. *Standard Oil Company of California*, 395 U.S. 642, 647 (1969).

The Robinson-Patman Act was enacted in 1936 to prohibit all devices by which large buyers gained discriminatory preferences over smaller ones by virtue of their greater purchasing power. *Federal Trade Commission* v. *Fred Meyer, Inc.*, 390 U.S. 341, 349 (1968).

In the absence of an unmistakable directive, the Court has refused to construe legislation aimed to protect a certain class in a fashion that will run counter to the goals Congress clearly intended to effectuate. *National Labor Relations Board* v. *Plasterers' Local Union No. 79*, 404 U.S. 116, 130 (1971).

Here the "non-profit" hospitals are large buyers while respondent's assignors and other community pharmacies are relatively small buyers. They compete with each other for retail drug sales when hospitals resell the drugs for a nonhospital use.

The special break given by the § 13c exemption

by its terms applies only where the exempt institution, in this instance, "non-profit" hospitals, were not engaged in commercial competition with other buyers.

THE COMPETITION ISSUE

The Robinson-Patman Act and its narrow § 13c exemption should be construed together to accomplish the major purpose of the Act — preservation of competition.

Competition cannot be preserved when "non-profit" hospitals receive unfair preferential prices and conditions denied community pharmacies on the pretext the drugs are for the hospitals' own use, but then resell the drugs in unfair price competition with community pharmacies.

The decision does not interfere with any hospital drug function inside or outside of the § 13c exemption.

It merely holds that a drug company may not give a "non-profit" hospital a lower § 13c price than retail pharmacies on drugs resold to physicians for their private office practice and to others who are not hospitalized or emergency room patients.

PRIOR DECISIONS

Petitioners err at page 9 of their petition in claiming only one "prior Section 13c decision." Their fn. 6 at page 11 is misleading.

Judge Bazelon wrote the opinion and dissented

only on issues irrelevant here in *Students Book Company* v. *Washington Law Book Co., supra.*

In fn. 5 Judge Bazelon made a ruling of law as to the application of § 13c at 232 F.2d 50-51:

> ". . . the transactions here in question were not actually with the universities, but with the self-sustaining campus book stores, and *the books sold were not for the use of the universities, but for resale at a profit. The exemption provision is therefore inapplicable to these transactions.*" (Emphasis added).

Petitioners' reliance on *Logan Lanes* v. *Brunswick Corporation, supra,* is misplaced.

In that case the Court made clear the distinction between purchase of capital equipment for university use and resale of fungible supplies at a profit.

The Court said of *Students Book Company* v. *Washington Law Book Company, supra:*

> ". . . The court held that sales to self-sustaining campus bookstores for resale at a profit are not sales to universities within the meaning of section 13 of the Act. . . ."

Also see App. IV at A19, which lists 29 differences between the case at bar and *Logan Lanes.*

It is significant that the same Court issued *Logan Lanes* and the challenged decision.

In *Logan Lanes* bowling lanes (and related equipment) were purchased for and used by Utah State

University for the use of its physical education classes and recreational use of its students, faculty and staff. Only after they had been installed and used for some time did Utah State permit a few members of the general public to use the lanes on occasions, too. In distinguishing *Logan Lanes*, Judge Merrill said (A8):

> "Our case does not involve the acquisition of plant equipment. It involves acquisition of stores of supplies. Plant equipment acquired for a university's own use cannot be segregated from that acquired for use by others, since the same equipment serves both uses. In the case of stores of supplies acquired for consumption the situation is otherwise. Supplies that are resold can readily be segregated from those devoted to a hospital's own use."

PETITIONERS' CASES IRRELEVANT

Petitioners err in claiming in fn. 4 at page 9 that § 13c "includes new hospital uses as well as those which were then common." Their footnote citations do not support their contention. None of the cases cited deal with 13c.

Petitioners did not advise the Court that one of the decisions relied on is not final because both sides have appealed the ruling: *Eastern Kentucky Welfare Rights Organization* v. *Simon*, 506 F.2d 1278 (D.C. Cir. 1974) (2-1 decision; rehearing en banc denied by split vote); Dkt. 74-1110, filed March 6, 1975, and Dkt. 74-1124, filed March 8, 1975.

The Court of Appeals held at 506 F.2d 1289 that "to qualify as a tax exempt charitable organization, a hospital must still provide services to indigents."

In other words, despite changes in hospital function, a tax exempt hospital must continue to provide charity.

Fortnightly Corporation v. *United Artists Television, Inc.*, 392 U.S. 390 (1968) supports respondent's position that a statute is construed as of the date of enactment and under the circumstances existing at that time.

The Court held at 392 U.S. 401-402:

> "We have been invited by the Solicitor General in an *amicus curiae* brief to render a compromise decision in this case that would, it is said, accommodate various competing considerations of copyright, communications, and antitrust policy. We decline the invitation. That job is for Congress. *We take the Copyright Act of 1909 as we find it.* With due regard to changing technology, we hold that petitioner did not under that law 'p e r f o r m' the respondent's copyrighted works." (fns. omitted) (Emphasis added).

To the same effect is another case cited by petitioners: *Browder* v. *United States*, 312 U.S. 335 (1941). The Court held at 312 U.S. 339-340:

> ". . . Old laws apply to changed conditions. The reach of the act is not sustained or opposed by the fact that it is sought to bring new situations under its terms. While a stat-

ute speaks from its enactment, even a criminal statute embraces everything which subsequently falls within its scope. . . ." (fns. omitted).

The fact that since 1938 "non-profit" hospitals have become (1) less charitable, (2) more commercial and profit-making, and (3) now compete commercially with retail pharmacies does not warrant judicial amendment of 15 U.S.C. §§ 13 and 13c.

Gulf Oil Corporation v. *Copp Paving Company*, — U.S. —, 95 Sup. Ct. 392, 402 (1974) rejected statutory expansion by judicial decision.

Rogue River Valley Irrigation District v. *Employment Division*, — Or. App. —, — P.2d —, decided April 14, 1975, App. VII at A39 applies the familiar rule that exemptions are construed narrowly and that profit-making activities can jeopardize an exemption.

In the case at bar there is substantial evidence of substantial profits from "non-profit" hospital drug sales.

If hospital drug sale practices have expanded since 1938, § 13c has not, and must be interpreted as of the year it was enacted — 1938.

Petitioners and *amicus curiae* American Hospital Association concede that in 1938 "non-profit" hospitals did not sell drugs to nonpatients.

Appendices VIII, IX and X at A43 et seq. are post-summary judgment trial court file affidavits. They establish without contradiction that hospital drug

sales to nonpatients are a post-1938 development outside the scope of § 13c legislative intent.

Statutes are construed with reference to the circumstances existing at time of passage. *United States* v. *Wise*, 370 U.S. 405, 411 (1962); *Civil Aeronautics Board* v. *Delta Air Lines, Inc.*, 367 U.S. 316, 323 (1961), and *United States* v. *Champlin Rfg. Co.*, 341 U.S. 290, 297 (1951).

As held in *United States* v. *Rothberg*, 480 F.2d 534, 535 (2d Cir. 1973), cert. den., 414 U.S. 856: "In construing a statute to determine the intent of Congress, we must do so in light of the conditions under which the Congress did act. . . ."

Statutory language is read in light of its purpose and legislative history. *Gulf Oil Corp.* v. *Copp Paving Company, supra*, 95 S. Ct. 399.

There is nothing in the trial court file or the petition to support petitioners' alleged "reason" at page 6 for granting the writ that the decision "adversely affects the purchase of hospital drug supplies throughout the United States. . . ."

The claimed adverse effect is not explained.

It is not the fact.

A hypothetical, unsupported claim of an unspecified adverse effect on non-parties is not a ground for granting the writ.

Appendix XI at A57 is a January 15, 1975 Oregon Association of Hospitals newsletter by its Associate Director and Legal Counsel. The newsletter ad-

vised its members to comply with the decision. OAH members appear to be doing so without difficulty or upset.

PETITIONERS' POLITICAL ARGUMENTS SHOULD BE REJECTED

Petitioners—without record or factual support — have made a vast number of unfounded and unsupportable arguments, which request this court to repeal the clear and unmistakable language of 13c, which limits the exemption to "purchases of their supplies for their own use . . . ." While better addressed to Congress, nevertheless we do not wish the record to reflect inaccuracy either. For example:

(a) *Costs:*

It is not true that hospitals—and certainly not the public—will be faced with increased costs if this law is enforced according to its clear tenor, as the Court of Appeals has done.

For example, petitioner manufacturers may continue to sell to hospitals at favorable prices with respect to drugs used in the hospital and in the emergency room. The only restriction is that if they sell drugs to hospitals, which are not intended for hospital use but instead for resale, the price charged to the hospital and a competing neighborhood pharmacy be the same.[1]

[1] And, of course, this exemption is not a matter of being supine, either, as the *amicus* brief facetiously characterizes our stance. Of course, it would not matter whether the inpatient or emergency patient was horizontal or vertical at the time he or she receives the drug.

If hospitals wish to act as sub rosa drug stores by reselling the drugs to nonhospitalized persons (which, of course, they are privileged to do), then why should they not pay the same price as neighborhood drug stores with whom they would then compete on that part of their purchases? Or why should a neighborhood drug store be penalized by a higher price because it truthfully calls itself a 'drug store' rather than a 'hospital pharmacy' in those instances where they conduct their business in precisely the same way?

If this court were to place its imprimatur on disparate prices merely because one purchaser is called a hospital pharmacy and another a drug store, what is to preclude the *xxx* hospital from opening a branch pharmacy at a location remote from the hospital? Would Doctors Hospital, for example, be permitted to open a so-called hospital pharmacy next to Dart Drug at 11th & G, and use its leverage of discriminatory prices to obliterate the latter?

In fact, this is already being done in Portland by the Kaiser Hospital and satellite pharmacies, with devastating effect on the drug stores in the vicinity.

(b) *Bookkeeping:*

It is not true that hospitals will be faced with a crushing bookkeeping task in separating drugs which they use in the hospitals from those which they sell for use outside the hospitals to third persons or members of their staffs, etc. The fact is that the hospitals keep such records now. Prescriptions are invariably written—and indeed are required to be written—where

the drugs are not given to hospitalized patients. It has never been felt necessary to our knowledge to keep the two sets of drugs in different receptacles. No change would be necessary.

(c) *Convenience to the public:*

Throughout petitioners seem to imperiously assume that the general public is somehow better served if hospitals are given a better break than are drug stores, even where the hospitals act exactly like drug store by selling indiscriminately to members of the general public. We cannot buy such contemptuous assertion. The only real question, we submit, is whether the public is to be given a choice or not. If the hospitals are to be favored in such uneven and unfair struggle, by buying the drugs for pennies while druggists are required to pay dollars for the same, then it is only a matter of time before the latter succumb. If such occurs, the only result would be that the public would no longer have an option. No longer would it be able to go to the corner drug store for needed medications. It may have no choice but to travel whatever distance necessary to reach the nearest hospital pharmacy, and to pay whatever price may be exacted. The resultant added travel can only aggravate the energy crisis which confronts us all.

(d) *Operation of a Modern Hospital:*

Petitioners have fantasized that the Court of Appeals ruling will somehow preclude hospitals from operating as modern hospitals or providing outpatient

care. Nothing could be farther from the fact. No change whatever is requested in the operation of hospitals, as petitioners must surely know. We ask only one thing—that if petitioners dispense under-the-table discounts to hospitals, for products which are not intended for hospital use, that the same break be given to neighborhood pharmacies for those products where they compete.

We concede that hospitals' expenses have risen. But so have those of neighborhood pharmacies. Why should one be advantaged more than the other in those respects where they compete?

(e) *Outpatients:*

Stressed in petitioners' brief is that outpatient clinics will be precluded or hampered. There is no factual or record support for this.

In reality, there is no reason that outpatient clinics would be disrupted, or changed in the slightest.

Anyone visiting an outpatient clinic for emergency treatment would be covered by the court's ruling, which allows price breaks for those supplies dispensed during "treatment to patients at emergency clinics."

Moreover, petitioners may continue to charge the same price they have been charging to hospitals even for those drugs never intended to be used on the hospital premises, providing only they do not discriminate against neighborhood pharmacies.

(f) *End Use of the Proceeds:*

Petitioners also argue that hospitals should be permitted to buy their products at discriminatory prices because they frequently use the money thus derived from such unfair leverage to noble ends, such as expansion of plant facilities, etc.

This is only an ill disguised "ends justify the means" argument clad in different raiment. Similar arguments for other violations of the law have always been summarily rejected.

The general rule, reinforced by the Tax Reform Act of 1969, makes the source of the profits, not the "use" or "destination" of the profits controlling for tax exemption purposes. If the source is outside the tax exemption, as is the case here, what is done with the profits from unrelated commercial business income is irrelevant. *Louis W. and Maud Hill Family Foundation* v. *United States*, 347 F. Supp. 1225, 1227 (Minn. 1972); *University Hill Foundation* v. *C.I.R.*, 446 F.2d 701 (9th Cir. 1971), cert. den., 405 U.S. 965.

The effect of the repeated and persistent discriminatory pricing by petitioners has been catastrophic. More than half of the neighborhood[2] pharmacies in

[2] The number of community pharmacies in the Portland area which have gone out of business is (R. 541-542):

1972 — 7	1965 — 7	1959 — 0
1971 — 7	1964 — 2	1958 — 0
1970 — 11	1963 — 8	1957 — 2
1969 — 6	1962 — 1	1956 — 0
1967 — 8	1961 — 4	1955 — 1
1966 — 8	1960 — 1	1954 — 2

the Portland area have perished within the past ten years.

The extent of diversionary sales is massive. One hospital alone in the Portland area to whom defendants made discriminatory sales, filed 216,958 prescriptions for nonhospitalized individuals between December 26, 1967 and May 8, 1973 (R. 832). Another—231,061 between July 1, 1970 and April 12, 1973. A third filed 49,435 new prescriptions between August 23, 1968 and May 11, 1973. A fourth, 48,759 new prescriptions between March 29, 1969 and March 16, 1973. A fifth, 38,045 between March 15, 1971 and March 9, 1973. A sixth, 17,803 between February 2, 1971 and February 2, 1973.

Each prescription necessarily means a sale to a nonhospitalized patient; for those who are still patients receive merely an intrahospital order, not a prescription number. (R. 755-6).[3]

It is also more than coincidental that the highest rate of attrition of Portland pharmacies is in the immediate area of the hospitals who have received discriminatory price breaks from defendants.

[3] Petitioners err when they assert that the record does not show that there were hospital sales to physicians for use in their private practices, refills of "take-home" prescriptions, and occasional sales to "walk-in" customers (members of the public having no connection with the hospitals) in "legally significant amounts." (Pet. Br. 8, ftn. 3).

Nothing could be further from the truth.

The record is replete with references to such sales, even though the district court has allowed only the barest discovery imaginable, and only the tip of the iceberg has yet emerged. However, even that tip is of massive proportions.

To make matters infinitely worse, the District Judge even refused to enter an order which would have prevented the destruction of records by defendants during the pendency

Assuming *arguendo* the possibility of some adverse effect on non-parties, relief should be sought from the legislative, not the judicial branch of government. *Anchor Serum Company* v. *Federal Trade Commission*, 217 F.2d 867, 873 (7th Cir. 1954).

American Society of Hospital Pharmacists Supports Decision

Petitioners' false alarms are refuted by the action of the American Society of Hospital Pharmacists.

The Society supports the principle of the decision.

The national professional organization is best qualified to declare whether the decision may be harmful to hospitals.

App. XII quotes part of the inaugural address April 23, 1975 in San Francisco of Fred M. Eckel, Society President.

Mr. Eckel said the Society's board of directors "discussed the Portland case and the underlying principles of preferential pricing at length" and reached the following consensus of opinion:

> "The American Society of Hospital Pharmacists:
>
> (1) opposes in principle the preferential pricing of drugs except when based

of this action, while simultaneously preventing us from having discovery of such records. Defense counsel were, evidently, taken aback by this ruling, and ultimately stipulated to a limited form of non-destruction of records order.

> on volume discounts that are available to all purchasers;
>
> (2) believes that noninstitutional purchasers should enjoy the same prices now available to many institutional purchasers. . . ."

The Society resolution states respondent's objective:

(1) The end of price discrimination where "nonprofit" hospitals compete commercially with community pharmacies for retail drug sales;

(2) Even-handed treatment for all competitors.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

ROGER TILBURY
HENRY KANE

April 29, 1975

APPENDIX I

90th Congress, 2d Session - - - - - - Union Calendar No. 839
House Report No. 1983

SMALL BUSINESS PROBLEMS IN THE DRUG INDUSTRY

A REPORT

OF

SUBCOMMITTEE NO. 5

TO THE

SELECT COMMITTEE ON SMALL BUSINESS

HOUSE OF REPRESENTATIVES

NINETIETH CONGRESS

SECOND SESSION

PURSUANT TO

H. Res. 53

A RESOLUTION CREATING A SELECT COMMITTEE TO CONDUCT STUDIES AND INVESTIGATIONS OF THE PROBLEMS OF SMALL BUSINESS

DECEMBER 31, 1968.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE

98-006 WASHINGTON : 1968

CHAPTER IV. CONCLUSIONS

After studying the body of testimony and other evidence received by it during the course of its hearings, the committee has reached the following conclusions:

1. There is little or no price competition in the marketing of trademarked pharmaceutical products among manufacturers. According to the testimony of manufacturers themselves, demand is highly price inelastic, but depends rather upon therapeutic efficacy and sometimes even more upon vigorous and continuing promotion, particularly in the work of so-called detailmen in convincing physicians they should prescribe a particular drug by its trademark name.

Since neither the pharmacist nor the patient is free to substitute another product for that prescribed, it can readily be seen that price competition cannot be a controlled factor in determining demand.

2. The difference between drug prices charged retailers and wholesalers as compared to those charged institutional and governmental customers is extremely substantial, often being over 50 percent. According to testimony in the record of the hearings, this differential is not always fully explainable by either cost justifiable quantity discounts, economies of scale, or other factors inherent in bulk distribution. Donald Van Roden, vice president and general manager of pharmaceutical operations, of Smith, Kline & French, verified this during his appearance before the committee.

To the extent that a greater differential is granted to institutional customers than is justified by the economics of the transaction, it is clear that retail pharmacists and their customers are subsidizing that transaction.

3. Numerous acts and policies of individual manufacturers seem and in some instances appear violative of the Robinson-Patman Act or other antitrust statutes.

4. A number of manufacturers appear to be genuinely interested in and concerned with the preservation and fostering of small business drug wholesalers and retailers as full-fledged members of the Nation's health team.

5. From its continuing study of the subject matter the committee believes that some change for the better may have commenced on the part of some drug manufacturers since the hearings were concluded. It is the hope of the committee that voluntary action will continue and increase to the extent necessary to correct the situations harmful to small business described in the testimony received during the hearings.

6. More vigorous action is required at the earliest possible time on the part of the Federal Trade Commission to enforce the Robinson-Patman Act and other statutes administered by it if small business drug wholesalers and retail pharmacists are to continue their important role in serving the Nation's health needs.

* * *

8. There is considerable testimony of record relating to discriminatory prescription drug sales between classes of competitors at the nongovernmental health-care institutional level and the retail pharmacy level of prescription drug competition. Nongovernmental health-care institutions, notably profit and nonprofit hospitals, clinics, nursing homes, physicians in private practice, and the like, are in competition with neighboring retail druggists to the extent that both classes sell prescription drugs to the general consumer, to people off the street, to private nonhospitalized patients of physicians, and to people with the physical mobility to shop for prescription drugs in the community.

It is reasonable to infer from the testimony on this subject that there has been a widespread practice by many nationally prominent drug manufacturers granting large drug price concessions to such institutional buyers without regard to the realities of prescription drug competition at the retail level. Such events were dramatically illustrated by the testimony of Mr. James Scully, a New Jersey retail pharmacist. The institution here in issue is a private nonprofit hospital in Woodbury, N. J. Seven or eight community drugstores are located in this trading area, most of them within 2 miles of the hospital. This hospital maintained a pharmacy facility convenient to and among other things for the purpose of selling prescription drugs to people off the street, and to others who were not hospitalized patients. This nonprofit hospital received across-the-board price concessions directly

from national drug manufacturers of one-third to two-thirds less than the price competing pharmacies paid the same drug manufacturers on a direct-buying basis for the same drugs. The resulting adverse competitive effects of such concessions at the retail druggist level of competition are believed to be quite clear. In other words, were it not for the exempt status of nonprofit institutions, such pricing would not be permitted. This is not an isolated situation, but widespread according to the testimony of a large number of both retailers and wholesaler witnesses.

The drug price concessions to these institutional buyers has been of such great magnitude that some have entered the marketplace as de facto wholesalers, selling to retail druggists in competition with drug wholesalers.

The Nonprofit Institutions Act of 1938 is designed to afford immunity to private nonprofit institutions (like hospitals so organized), from the prohibitions of the Robinson Patman Act to the extent the sales are for the nonprofit institution's "own use." The Nonprofit Institutions Act does not apply to institutions organized for profit.

When a profit or a nonprofit hospital purchases drugs for its "own use," this purpose is for a different function, i.e., unit doses for hospitalized patients rather than for resale at the retail drug distribution level. In such "own use" purchases, at least in the contemporary climate of drug distribution in the United States, the hospital is not thereafter compet-

ing with retail druggists, because of such functional difference. Conversely, when the drug sales are not for such hospital's "own use," but rather for general consumer resales, the institution is competing with the retail druggist because it is functioning in a competitive sense just like a retail druggist.

This same result occurs when a "for-profit" health care institution buys drugs for its "own use" on one hand, or retail drug sales on the other hand. The Robinson-Patman Act is concerned with the realities of competition, not labels (*Federal Trade Commisison* v. *Simplicity Pattern Co.*, 360 U.S. 55 (1959)).

There is no basis apparent from the record why the mandate of the Robinson-Patman Act should not be applied to discriminatory drug sales favoring nongovernmental institutional purchasers, profit or nonprofit, to the extent there is prescription drug competition at the retail level with disfavored retail druggists. Consumer interests are compromised by permitting drug price discrimination in the area, because the retailers and consumers ultimately must pay higher drug prices as a form of economic subsidy to the drug supplier for the lower prices which that drug supplier charges the institutions.

To be sure, there may be a gray area in determining where own-use purchasers leave off and retail competition begins with the private institutional health-care purchaser. This gray area centers on so-called outpatient dispensing by health-care institutions. While the term "outpatient" is not susceptible

of one simple definition which embraces all hospitals, the following factors appear to apply:

(1) An "outpatient" is a person who, although receiving hospital services, is not a confined, hospitalized patient;

(2) The outpatient, by virtue of not being hospitalized, presumably has the physical mobility to purchase prescription drugs from retail sources other than the hospital;

(3) Hospital drug sales to physically mobile outpatients therefore should be recognized as straightforward retail sales in direct competition with any other retail druggists in the community. The outpatient may be a captive customer or patient of the institution for other health-care services, but because of mobility, the outpatient is capable of securing his prescription needs in the community.

These issues of drug distribution have not been the subject of public enforcement proceedings by the Feedral Trade Commission, and the only private antitrust suit, known to the committee, which has been commenced in this area was never adjudicated on the merits.[1]

However, the sheer magnitude of the price dis-

[1] *Contra Costa Ph. Assn.* v. *Ciba Pharm. Products, Inc.*, Civ. No. 46218 (N.D. Calif. filed Dec. 28, 1966), *Students Book Co.* v. *Washington Law Book Co.*, F.2d 49, 50, Note 5. (D.C. Circuit Ct. 1955. Cert. denied 350 U.S. 988 (1956). Sale of books to college was within "own use" exemption but sale for profit by student bookstore was outside exemption.

criminations evident from the record of these hearings would seem to justify vigorous remedial action by the Federal Trade Commission. It is unreasonable to expect the remedy of private antitrust enforcement by disfavored retail druggists to serve as a sufficient deterrent to drug manufacturers' discriminatory pricing.

It should be made absolutely clear at this point that the findings of the subcommittee, which have just been stated, in no way lead to the conclusion that the solution to the problems raised is to increase the costs to institutional customers to the level of the present costs of retailers. The public interest requires, rather, that the often excessive gap between prices to wholesalers and retailers on the one hand, and institutional customers on the other, should be closed by lowering the price to retailers. Only in this way can those members of the public requiring drugs for the preservation of their health and, indeed, for their very life buy at prices which do not discriminate against them.

As pointed out herein above, there is an almost total absence of the usual type of price competition in the marketing of trademarked pharmaceuticals. For this reason, there is an almost unique duty on the part of drug manufacturers to substitute their judgment and self-discipline for the price regulating function traditionally played within our free enterprise society by competition in the marketplace. The continuing absence of such restraint can lead only to further governmental intervention of a type that would be less than welcomed by the drug manufacturers.

* * *

CHAPTER V. RECOMMENDATIONS

1. It is recommended that the Federal Trade Commission hold appropriate proceedings to determine the area of competition between hospital pharmacies and small privately owned community pharmacies and take such further action as may be necessary to define the application of the Robinson-Patman Act thereto. Emphasis should be placed on determining the parameters of the proper application of the "own use" exemption of the Non-Profit Institution Act of 1938.

2. It is recommended that the Federal Trade Commission proceed, on a case-by-case basis, to investigate the apparent violations of the Robinson-Patman Act shown by the testimony and evidence received during the course of the hearings on which this report is based. It is further recommended that the Commission and its staff determine whether similar violations are occurring elsewhere in the drug industry.

With respect to all cases where violations of the Robinson-Patman Act or other antitrust statutes are found, it is recommended that the FTC or the Antitrust Division of the Department of Justice take prompt, appropriate, and vigorous action against those found to be commiting such violations.

3. It is recommended that the Federal Trade Commisison, on or before January 15, 1970, report to the chairman of this committee the actions it has taken with respect to the two preceding recommendations.

4. It is recommended that this committee, during the 91st and each succeeding Congress, study both the structural and behavioral aspects of the distributive sector of the drug industry and their effect on small business, particularly toward the goal of obtaining lower prices for retailers and their customers.

• • •

APPENDIX II

NON-PROFIT INSTITUTIONS ACT REPORT

HOUSE OF REPRESENTATIVES

75TH CONGRESS
3rd Session

REPORT
No. 2161

EXEMPTION OF ELEEMOSYNARY INSTITUTIONS FROM THE ROBINSON-PATMAN ACT

April 19, 1938—Referred to the House Calendar and ordered to be printed

---

MR. WALTER, from the Committee on the Judiciary, submitted the following

REPORT

[To accompany H.R. 8148]

The Committee on the Judiciary, to whom was referred the bill H.R. 8148, to amend Public Law No. 692, Seventy-fourth Congress, second session, after consideration, report the same favorably to the House with an amendment with the recommendation that as so amended the bill do pass.

The committee amendment is as follows: "Strike out all of line 9."

The reported bill provides that the Robinson-Patman Act shall not apply to purchases of their supplies for their own use by schools, colleges, universities,

public libraries, churches, hospitals, and charitable institutions not operated for profit.

The Robinson-Patman Act prohibits price discriminations between purchasers in interstate commerce, excepting differentials which make only due allowance for differences in the cost of manufacture, sale, or delivery resulting from the different methods or quantities in which such commodities are sold and delivered, where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition.

The committee does not feel that the wholesome purpose of the Robinson-Patman Act will be interfered with by the enactment of this bill to make certain that favors in price which are occasionally extended to eleemosynary institutions, because of the character of the institution, do not fall under the ban of the act.

In this connection there follows a self-explanatory communication from the president of the Hospital Bureau of Standards and Supplies, a nonprofit-making association of 200 voluntary hospitals located from Maine to Texas:

HOSPITAL BUREAU OF STANDARDS AND SUPPLIES,
New York, N. Y., December 18, 1937.

Hon. H. W. SUMNERS,
United States House of Representatives
Washington, D. C.

MY DEAR CONGRESSMAN: The 2,700 voluntary nonprofit hospitals of the country spend over 150 million dollars a year on foodstuffs and supplies for the care of the needy sick, who would otherwise be a burden on Federal, State, and municipal institutions.

Because of the charitable nature of their work many suppliers have hitherto allowed these institutions special prices on their purchases. This the Robinson-Patman Act now prohibits and as a consequence, hospital supply bills are increasing about 20 percent.

Most, if not all, of these institutions have for years operated at a deficit. If these deficits are to be increased by 30 million dollars a year, many hospitals may have to close their doors. The needy sick must be cared for and such a development would throw an almost impossible additional burden on the Federal, State, and municipal institutions.

We, therefore, respectfully request that you keep these facts in mind when the proposed amendment to the Robinson-Patman Act, exempting the eleemosynary institutions of the country, comes up for consideration of the Congress.

Sincerely yours,

JOHN H. HAYES, *President.*

75TH CONGRESS
3d Session

REPORT
No. 1769

SENATE

EXEMPTION OF ELEEMOSYNARY INSTITUTIONS FROM THE ROBINSON-PATMAN ACT

APRIL 20 (calendar day, MAY 10), 1938.
Ordered to be printed

MR. LOGAN, from the Committee on the Judiciary, submitted the following

REPORT

[To accompany H.R. 8148]

The Committee on the Judiciary, to whom was referred the bill (H.R. 8148) to amend Public Law No. 692, Seventy-fourth Congress, second session, after consideration of the same, report favorably thereon to the Senate with the recommendation that it do pass.

The bill provides that the Robinson-Patman Act shall not apply to purchases of supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit.

The purpose of the Robinson-Patman Act, to prohibit price discrimination between purchasers in interstate commerce where competition would thereby be lessened, does not seem to apply as to eleemosynary institutions as they are not operated for profit. The

act does forbid such favors as might now be granted by sellers to such institutions.

There follows a self-explanatory communication from the president of the Hospital Bureau of Standards and Supplies, a nonprofit association of hospitals, which letter was considered by the House.

• • •

APPENDIX III

§ 1.513 [Comprises Code section 513, see 26 U.S.C.A. (I.R.C. 1954) § 513]

§ 1.513-1 Definition of unrelated trade or business

(a) In general. As used in section 512 the term "unrelated business taxable income" means the gross income derived by an organization from any unrelated trade or business regularly carried on by it, less the deductions and subject to the exceptions, additions and limitations provided in section 512. Section 513 specifies with certain exceptions that the phrase "unrelated trade or business" means, in the case of an organization subject to the tax imposed by section 511, any trade or business the conduct of which is not substantially related (aside from the need of such organization for income or funds or the use it makes of the profits derived) to the exercise or performance by such organization of its charitable, educational or other purpose or function constituting the basis for its exemption under section 501 (or, in the case of an organization described in section 511(a) (2) (B), to the exercise or performance of any purpose or function described in section 501(c) (3)).

* * *

Therefore, unless one of the specific exceptions of section 512 or 513 is applicable, gross income of an exempt organization subject to the tax imposed by section 511 is includible in the computation of unrelated business taxable income if (1) it is income from trade

or business, (2) such trade or business is regularly carried on by the organization, and (3) the conduct of such trade or business is not substantially related (other than through the production of funds) to the organization's performance of its exempt functions.

(b) Trade or business. The primary objective of adoption of the unrelated business income tax was to eliminate a source of unfair competition by placing the unrelated business activities of certain exempt organizations upon the same tax basis as the nonexempt business endeavors with which they compete. In general, any activity of a section 511 organization which is carried on for the production of income and which otherwise possesses the characteristics required to constitute "trade or business" within the meaning of section 162—and which, in addition, is not substantially related to the performance of exempt functions —presents sufficient likelihood of unfair competition to be within the policy of the tax. Accordingly, for the purposes of section 513 the term "trade or business" has the same meaning it has in section 162, and generally includes any activity carried on for the production of income from the sale of goods or performance of services. Thus, the term "trade or business" in section 513 is not limited to integrated aggregates of assets, activities and good will which comprise businesses for the purposes of certain other provisions of the Internal Revenue Code. Activities of producing or distributing goods or performing services from which a particular amount of gross income is derived do not lose identity as trade or business merely because they

are carried on within a larger aggregate of similar activities or within a larger complex of other endeavors which may, or may not, be related to the exempt purposes of the organization. *Thus, for example, the regular sale of pharmaceutical supplies to the general public by a hospital pharmacy does not lose identity as trade or business merely because the pharmacy also furnishes supplies to the hospital and patients of the hospital in accordance with its exempt purposes or in compliance with the terms of section 513(a).* * * * (Emphasis added).

APPENDIX IV

Differences Between Logan Lanes and Case at Bar

	Logan Lanes	*Case at Bar*
1.	One plaintiff at one location.	Some 60 community pharmacy assignors in three metropolitan counties.
2.	One favored purchaser at one location.	14 favored "nonprofit" hospital purchasers in three counties.
3.	Purchaser a public body automatically exempt by 15 U.S.C. § 13c as one of a class of "universities."	14 private organizations. Affiliate of Bess Kaiser Hospital subject to taxation as a membership organization.
4.	Purchaser tax-exempt as a state institution.	Pharmacies of two of the 14 favored purchasers, Kaiser and Gresham hospitals, on the Multnomah County property tax rolls because of their drug sales to the public. R. 653-655). Two of the 14 "nonprofit" hospitals — Kaiser and Willamette Methodist — pay federal income taxes on their drug sales.
5.	One-time capital equipment item purchased for some $80,000; must be	Continuous purchases of small unit, fungible drug product supplies for (1) internal hospital use and

	purchased as a unit.	(2) for resale.
6.	University bowling equipment not resold.	Drug products resold at "substantial profits." (Pet. App. A3).
7.	Capital equipment purchased for proper use.	Drug products at issue resold *inter alia*, to physicians at subsidized prices for resale in their private office practice, and to "walk-in" members of the general public.
8.	Evidence of public use of bowling equipment *de minimis*.	Admitted evidence of substantial drug sales to, *inter alia*, the general public without restriction, *i.e.*, Rosco Pirtle dep. pp. 8-14, and Pirtle dep. ex. 2.
9.	Plaintiff allowed to make discovery.	District Court refused to allow respondent to make discovery of evidence in petitioners' exclusive possession, *i.e.*, Tr. 9/11/72, p. 115, lines 16-19; R. 425-427.
10.	No evidence of profit to university.	Drug profits substantial. Pet. App. A-3.
11.	No evidence of damage to plaintiff.	Stipulated evidence of 50 per cent decline in number of Portland community pharmacies, R. 541-542. Also see R. 125, lines 11-12.

12.	No evidence that supplier-defendant considered outside use improper.	Three petitioners, by written contract, attempt to limit use to hospital use only; diversion considered improper: A. H. Robins (R. 530); Eli Lilly (R. 491 and Fawkes dep. ex. 8), and Carter-Wallace, Inc. (Fawkes dep. ex. 9). Also see R. 656.
13.	No evidence of diversion of bowling equipment.	Admitted evidence of diversion from hospitals of drugs purchased at § 13c prices to, *inter alia*, physicians for resale in their private office practice, *i.e.*, Scott dep. ex. 27A reflects Kaiser Hospital resale of $543,961.15 in drugs to physicians' group. Also see Scott dep. 10/20/72, p. 27, lines 6-10; and deposition excerpts at R. 544 to 549.
14.	Court did not block any effort to discover improper diversion.	District Court refused to allow respondent to make discovery of admitted Kaiser Hospital drug diversion from hospital. R. 282-287; R. 386, lines 7-11.
15.	No evidence that plaintiff lost customers to university	Substantial evidence that assignors lost customers to 14 "non-profit" hospi-

	because school purchased bowling equipment at lower price than plaintiff.	tals because of discriminatory prices enjoyed by hospitals, *i.e.*, R. 113, lines 8-26.
16.	No evidence of compulsory bowling equipment use sales by university.	Two victims testified to compulsory purchase of drugs from hospital contrary to their expressed wishes: Alan T. Carlston dep. and Betty Marie Pye dep.
17.	No use of bowling equipment off university grounds.	Substantial admitted evidence of drugs purchased from hospital consumed away from hospital premises, *i.e.*, Greenlick dep. ex. 2 at 2-14 and Pirtle ex. 2.
18.	No evidence of overcharging.	Admitted evidence of illegal overcharges to Public Welfare Division of State of Oregon. Fawkes 12/21-/72 dep. p. 33, line 14.
19.	No evidence of effect on competition.	Evidence of substantial effect on competition.
20.	No congressional investigation.	House Small Business Committee investigated and criticized, *inter alia*, preferential drug prices to hospitals which resold drugs in competition with retail pharmacies. App. II at A 1.

21.	Ruling for plaintiff would have raised cost to university on future equipment purchases for university use.	Ninth Circuit ruling does not increase cost to hospitals for "own use" drug purchases. At most they would pay market price for drugs sold for resale outside the § 13c exemption.
22.	District Court not in doubt as to decision.	District Court expressed some doubts. Pet. App. A 14-15.
23.	No private profit to an individual.	Permanente Clinic physicians share in Kaiser Hospital net profits. R. 496; Scott dep. 12/14/72, pp. 36-37 and Scott dep. ex. 17B. Pet. App. A 4-5. Physicians who purchased drugs from hospitals profited indirectly from lower prices granted the hospitals.
24.	No goods resold.	Drugs resold, *inter alia*, to physicians for their office use and resale to office patients.
25.	No restrictive Internal Revenue Service rulings.	IRS revenue rulings classify some hospital drug sales as taxable unrelated income. R. 721 through R. 725.
26.	No restrictive court decisions.	Recent court decisions require "nonprofit" hospi-

		tals to provide some charitable care, *i.e., Eastern Kentucky Welfare Rights Organization* v. *Simon*, 506 F.2d 1278, 1289, D. C. Cir. 1974) (J. Skelly Wright, dissenting in part); petitions for certiorari pending: Dkt. 74-1110, filed 3/6/75, and Dkt. 74-1124, filed 3/8/75.
27.	No stipulated evidence.	See, *inter alia*, Montee affidavit re hospital drug purchases. R. 343-346.
28.	Defendant Brunswick offered affidavits in support of motion.	No petitioner offered affidavit in support of the summary judgment motion.
29.	Limited trial court file.	Extensive trial court file: R 1-986, 47 depositions and numerous exhibits plus transcript of nine separate court proceedings between Sept. 11, 1972 and May 25, 1973.

APPENDIX V

April 13 and 18, 1975 Letters to Petitioners

April 13, 1975

• • •

It is respectfully submitted that there are a number of errors in the petition that should be corrected in the interest of factual accuracy.

1. The table of citations list the first five cases as being on page 11, when they appear to be on page 10;

2. The table of citations lists *Logan Lanes* as being on page 10 instead of page 9, does not list the page 11 reference, and states incorrectly that it appears on page 13;

3. The table of citations lists *Jerome H. Remick & Co.* v. *American Automobile Accessories Co.* at page 11 instead of page 10;

4. *Students Book Company* v. *Washington Law Book Co.* is listed at page 12 instead of at page 11;

5. The table of citations does not refer to references to *Logan Lanes* and *Students Book Company* in Appendix A;

6. The reference to *Eastern Kentucky Welfare Rights Organization* v. *Simon*, 406 F.2d 1278 (D.C. Cir. Oct. 9, 1974) is incomplete because it does not make reference to the fact that petitions for certiorari were filed (dkt. 74-1110, filed 3/6/74 and dkt. 74-1124 filed 3/8/75);

7. The Statement of the Case at page 4 of the petition claims that plaintiff-respondent filed a complaint "charging petitioners with violations of the Robinson-Patman Act" when, in fact the complaint also charges violation of the Sherman Act (see page 1, lines 29-32 of the amended complaint and page 2, lines 1-3 of the amended complaint); the statement is misleading as well as incorrect;

8. The Statement of the Case at p. 4 of the petition is misleading. It refers to five counts, lists four, and neglects to mention that on the Fifth Cause of Action, the antitrust claim, the court has refused to allow any discovery;

9. The Statement of the Case at pp. 4-5 of the petition is misleading in that it fails to advise the Supreme Court that various defendants denied all allegations relevant to the issue at bar, paragraphs 20 et seq. of the amended complaint;

10. The Statement of the Case at p. 5 of the petition is incomplete and misleading because it fails to advise the Supreme Court that the trial court (1) refused to allow any discovery of any defendant on the Second Cause of Action and (2) refused to allow plaintiff-respondent to inquire of the hospitals concerning prices, terms and conditions of sale;

11. Despite the footnote, the Statement of the Case at p. 5 of the petition is misleading because the petition claims that "It affirmed the district court's decision that the hospitals were nonprofit institutions, [2] . . ."

12. The Statement of the Case at p. 5 of the petition is misleading in that the petition claims that ". . . it agreed with the district court that the record established the ways in which hospitals dispense drugs." I do not find any such agreement and further note that the trial court refused to allow discovery as to diversion of drugs from the Kaiser hospital facility; the Ninth Circuit said at A5: ". . . it appears that drugs were distributed by the hospitals under the following circumstances: . . . .";

13. Page 6 of the petition claims under reasons for allowing the writ that "The decision of the court of appeals adversely affects the purchase of hospital drugs. . . ." when, in fact, there is nothing in the trial court file or the petition to support the allegation;

14. Pages 7 and 8 of the petition are misleading in attempting to dispose of three important drug distribution categories by footnote, categories 4 and 8 and the no. 7 category of drug sales to physicians for dispensation in the course of their private practice;

15. Fn. 3 at p. 8 of the petition errs in claiming:

> "[3] The decision of the court of appeals lists three additional classes of hospital drug dispensing which the record shows do not occur in legally significant amounts: . . ."

The Kaiser sales to nonpatients alone are significant, defendants conceded during oral argument that they were relying on the *de minimis* defense, a defense rejected by the court of appeals, and plaintiff-respondent vigorously disputed by undisputed affidavits the

self-serving estimates of hospital witnesses;

16. Page 9 of the petition claims that the Ninth Circuit's ruling "Prevents Nonprofit Hospitals from Operating as Modern Hospitals Must in Order to Fulfill Their Responsibilities to the Public," when, in fact, there is nothing in the trial court file or the petition to support the quoted claim;

17. Page 11 of the petition errs in claiming that the Ninth Circuit ruling "is an Abrupt and Unfortunate Retreat From the Only Previous Construction of Section 13c, Which Has Been Until Now the Prevailing View of the Statute . . ." because of the prior ruling of *Students Book Co.* v. *Washington Law Book Co.* relied on and cited by the Ninth Circuit at A9;

18. Page 11 of the petition contains an erroneous statement in fn. 6:

> "[6] The Act was referred to in a footnote in an opinion *announcing, but dissenting from the decision* in *Students Book Company* v. *Washington Law Book Company*. . . ." (emph. added)

Judge Bazelon wrote the opinion and dissented only from matters irrelevant to the issue at bar.

In footnote 5 Judge Bazelon made a ruling of law at 232 F.2d 50-51:

> ". . . the transactions here in question were not actually with the universities, but with the self-sustaining campus book stores, and *the books sold were not for the use of the universities, but for resale at a profit. The exemption provision is therefore inapplicable to these transactions.*" (emphasis added).

[19.] Appendix D to the petition does not appear to be part of the trial court file; if I am incorrect, please so advise.

Because the plaintiff-respondent desires to file its response as soon as possible we request that defendants-petitioners advise whether they intend to make any corrections, and if so, which items.

We would be happy to stipulate that a substitute petition could be filed for the original one.

May we hear from you at your earliest convenience.

* * *

April 18, 1975

* * *

This confirms our discussion this date concerning proposed corrections to the petition for certiorari suggested in my April 13, 1975 letter to defendants' counsel.

You advised that some, but not all, of defendants' counsel met April 18, 1975 and decided that the petition shall stand as filed.

The petition appears to be in violation of U. S. Sup. Ct. Rule 23 4.:

> "4. The failure of a petitioner to present with *accuracy*, brevity, and clearness whatever is essential to a ready and adequate un-

derstanding of the points requiring consideration will be a sufficient reason for denying his petition." (emphasis added).

The petition appears to be in violation of U. S. Sup. Ct. Rule 23.1. (a):

"1. The petition for writ of certiorari shall contain in the order here indicated —

"(a) A reference to the official and *unofficial reports* of the opinion delivered in the courts below, if any, and if reported. . . . (emphasis added).

Portland Retail Druggists Association, Inc. v. *Abbott Laboratories, Inc.*, the decision appealed from, was unofficially reported in 1974-2 TRADE CASES, ¶ 75,-437 (9th Cir., filed Dec. 26, 1974).

And as noted earlier, Mr. McMurry's address appears to be incorrect.

* * *

April 18, 1975

* * *

APPENDIX VI

Amended Complaint

(R 52-77)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

U. S. District Court
District of Oregon
FILED
Nov. 22, 1971
ROBERT M. CHRIST, Clerk

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors, Plaintiff, v. ABBOTT LABORATORIES, et al, Defendants.	CIVIL No. 71-543 AMENDED COMPLAINT FOR DAMAGES AND INJUNCTIVE RELIEF UNDER THE ANTITRUST LAWS; JURY TRIAL REQUESTED

FIRST CAUSE OF ACTION

* * *

1. Jurisdiction and venue are founded upon the Clayton Act (38 Stat. 730, Oct. 15, 1914, Ch. 323, Title 15 USC § 13 et seq.) as amended by the Robinson-Patman Act (June 19, 1936, Ch 592, 49 Stat 1526) and other amendments, and upon the Sherman

Act (July 2, 1890, Ch 647, 26 Stat. 209), 15 U.S.C. § 1 et seq., and subsequent amendments, and on 15 U.S.C. §§ 1, 2, 8, 9, 13, 15, 22 and 26, and related sections.

* * *

20. Plaintiff's assignors are in direct competition with the favored customers of defendants for the patronage of ultimate consumers of defendants' drugs except enrolled patients hospitalized in the purchasing institution.

UNLAWFUL DISCRIMINATION

21. More than four years ago and continuing to and including the date of the filing of this amended complaint, defendants and each of them unlawfully discriminated against plaintiff's assignors in the course of interstate commerce, in the sale of drugs of like grade and quality, by granting discounts, allowances, compensation, payments, services, brokerage, terms, facilities, rebates and lower prices than said commodities were sold to plaintiff's assignors, and such favorable discounts, allowances, compensation, payments, services, brokerage, terms, facilities, rebates and lower prices were not made available to plaintiff's assignors on equal terms.

22. Defendants' drugs were sold in interstate commerce for use, consumption, resale or distribution within the United States and multiple sales took place in interstate commerce.

23. The unjust and unlawful differentials set

forth in paragraph 21 of this amended complaint are not attributable to differences in the cost of manufacture, sales or delivery resulting from the differing methods or quantities in which such commodities are to such purchasers sold or delivered.

24. The exemption given sales to schools, colleges, universities, public libraries, churches, hospitals and charitable institutions not operated for profit by 52 Stat. 446, c. 283, 15 U.S.C. § 13c, where the drugs are employed for their own use, is limited to drugs used exclusively within the confines of the purchasing institution for enrolled patients of the institutions while such patients are so confined and for no other purpose.

25. Sale or distribution of any drug purchased at a discriminatory discount, allowance, compensation, payment, service, brokerage, term, facility, rebate or lower price by a non-profit institution to any person other than an enrolled patient in the purchasing institution is a violation of Section 2 of the Clayton Act as amended by the Robinson-Patman Act, 15 U.S.C. § 13.

26. The exemption granted by 15 U.S.C. § 13c does not include cities, counties, states and the federal government other than in their capacities as operators of hospitals and charitable institutions not operated for profit when they administer drugs to enrolled patients.

27. Said acts of discrimination by defendants against plaintiff's assignors enable the favored competitors to offer drugs at no cost or nominal cost to their consumers and for sale at prices substantially

below the retail prices that must be charged by plaintiff's assignors if they are to remain in business. Thus, plaintiff's assignors have been and are rendered less able to compete, and competition in said line of commerce has been, and is, substantially lessened and impaired.

28. The unlawful discrimination of the defendants set forth herein compels plaintiff's assignors to pay a higher and discriminatory unit cost for drugs of the same type.

29. The unlawful discrimination of the defendants set forth herein subsidizes defendants' favored purchasers with unearned and unjustified lower prices at the expense of plaintiff's assignors.

30. The unlawful discrimination of the defendants set forth herein compels plaintiff's assignors to contribute all or a disproportionate share of defendants' profits on drugs.

31. Said acts of discrimination by defendants against plaintiff's assignors constitute subsidized or below-cost sales to the favored purchasers at the expense of the retail customers of plaintiff's assignors, with resultant injury of said assignors and to the general public.

32. Said acts of discrimination by defendants against plaintiff's assignors preclude said assignors from competing successfully and threaten to, and if continued, will, terminate said assignors as competitors in drugs and cause them irreparable damage and reduce the number of competitors and thereby tend

to create a monopoly, and to injure, destroy or prevent competition.

33. Said acts of discrimination by defendants against plaintiff's assignors have, to date, resulted in the failure of numerous community pharmacies in the State of Oregon, and unless said acts of discrimination are permanently enjoined, will result in the failure of an additional and substantial number of community pharmacies in the State of Oregon, including at least some of plaintiff's assignors.

34. Defendants, directly and indirectly, sell drugs to proprietary nursing homes, hospitals and other institutions at more favorable discounts, allowances, compensation, payments, services, brokerage, terms, facilities, rebates and lower prices than are made available to plaintiffs' assignors.

35. Said proprietary nursing homes, hospitals and other investor-owned institutions resell said drugs to staff personnel and to members of the public.

36. The defendants and each of them were and are aware that hospitals and other purchasers favored by defendants resell drugs to persons not confined to the hospital or other favored institution.

SECOND CAUSE OF ACTION

37. Plaintiff incorporates paragraphs 1 through 36 by reference.

38. Defendants, directly and indirectly, sell drugs to hospitals and other institutions not operated for

profit on more favorable discounts, allowances, compensation, payments, services, brokerage, terms, facilities, rebates or lower prices than are available to plaintiff's assignors. Such hospitals and other institutions not operated for profit subsequently resell such drugs to staff personnel and to members of the public who are not patients enrolled in said hospitals and other non-profit institutions.

* * *

FIFTH CAUSE OF ACTION

44. Plaintiff incorporates paragraphs 1 through 43 by reference.

45. Beginning more than four years ago at a date unknown to plaintiff's assignors and continuing to the date of the filing of this complaint, defendants and each of them, acting individually and/or collectively, have attempted to monopolize and to restrain trade or commerce in the sale of drugs, by engaging in activities designed to foster such objectives by means of a combination, contract and conspiracy with the other defendants and with other unknown co-conspirators, and by engaging in a combination, concert of action, agreement, and also through individual action.

46. Defendants have attempted to monopolize and to restrain trade or commerce in the sale of drugs, by engaging in activities designed to foster such objectives by means of a combination, contract and conspiracy with the plaintiff's assignors, and by engaging in a combination, concert of action, agreement,

and also through individual action. To further the objectives of said illegal actions, defendants have:

(a) Systematically discriminated with respect to discounts, allowances, compensation, payments, services, brokerage, terms, facilities, rebates or lower prices to other accounts who were in competition with plaintiff's assignors;

(b) Systematically attempted to cripple and inhibit the sales of drugs by plaintiff's assignors by the device of granting massive discriminatory favoritisms to the competitors of such plaintiff's assignors;

(c) Restricted the ability of the general public to purchase drugs from plaintiff's assignors because of the much higher prices which plaintiff's assignors were obliged to charge in order to recoup the overcharges which had been imposed upon them by defendants;

(d) Arbitrarily, unlawfully, unreasonably and knowingly prevented, suppressed and eliminated competition between retailers of drugs by such practices;

(e) Rechanneled and restructured the flow of interstate commerce by curtailing the freedom of the general public to shop for its drugs at the outlet of its choice, and forced those customers who did not have an entree with a favored outlet to pay an enhanced price;

(f) Prevented and inhibited the freedom of plaintiff's assignors from charging a competitive price for defendants' products, because of the practical neces-

sity of recouping the excessive and discriminatory prices charged by defendants and each of them;

(g) Effectively secured a preferred position for the favored segment of the pharmaceutical distribution industry, and thus directly and materially impeded and burdened interstate commerce.

* * *

APPENDIX VII

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Rogue River Valley Irrigation District,

Petitioner,

v.

Employment Division, Ross Morgan, Administrator,

Respondent.

Filed
April 14, 1975
COURT OF APPEALS

* * * * *

Judicial Review from Employment Division Referee.

Argued and submitted February 18, 1975.

* * *

Affirmed.

LANGTRY, P. J.

This appeal is the third of companion cases. . . . The petitioner irrigation district in this case was organized and exists, as do the others, under ORS ch. 545. The Employment Division had determined, as with the others, that petitioner is subject to the unemployment compensation Act as it was amended in 1973. ORS ch 657. As with the Klamath and Talent districts, a relatively small part of petitioner's deliv-

ered water is used for ornamental and gardening purposes on small tracts of land. It was testified that this nonfarm water constitutes approximately 3 percent of all water delivered. There is no dispute in this regard. The referee held that, on account of this small nonfarm use, the exemption of ORS 657.045(2)(c) does not apply to petitioner. If that were all there is to this case, it would be reversed on the basis of the decision in Klamath Irr. Dist. v. Employ. Div., supra.

However, petitioner has conceded that it has five or six active accounts for commercially used water for log ponds, concrete mixing, etc. Water is sold to these accounts without reference to water rights running with any particular land. In other words, regardless of the amount of profit the district may make therefrom, that portion of its operation is for profit. This was an additional reason for the referee's decision.

ORS ch 657 was extensively amended in 1971, according to legislative history, in order to incorporate therein 1970 amendments that had been made by Congress to the Federal Employment Tax Act. One of the changes thus accomplished was to add to the irrigation exemption the words "not owned or operated for profit." The part in question was re-enacted without change in 1973 and provides that "agricultural labor" includes labor

> ". . . in connection with the operation or maintenance of ditches, canals, reservoirs or waterways not owned or operated for profit used exclusively for supplying and storing water for farming purposes." ORS 657.045(2)(c).

The summary of changes submitted by the Employment division to the legislature at the time the 1971 amendment was under consideration simply related that the addition of these words was so "farm irrigation projects operated for profit will be covered." House Judiciary Committee Minutes. Nothing more appears to have been said about this particular change.

For the reason that petitioner concedes the sale of the commercial water is a profit operation, the referee correctly held the petitioner is subject to the Act.

Affirmed.

LEE, J., specially concurring.

I concur in the result of the majority opinion and with the stated reason for holding for the respondent (i.e. the failure of the petitioner to qualify, as non-profit-making, for the ORS 657.045(1) and (2)(c) exemption).

However, I believe the majority is mistaken in indicating that but for the profit-making nature of the district's contracts with 'five or six active accounts for commercially used water," the case should be reversed.

The record discloses that petitioner also supplies water to the Medford Corporation log pond and 338 other accounts (constituting approximately three percent of the total water supplied) for tracts of one

acre or less in size in the city of Medford where the water is used for "lawns" and "gardens" of a "household" variety.

I would affirm for the same reasons set forth in my dissent in Klamath Irr. Dist. v. Employ. Div., — Adv. Sh. —, — Or. App. —, — P.2d — (April 14, 1975).

APPENDIX VIII

HOWARD STEINBACH AFFIDAVIT RE NON-PROFIT HOSPITAL DRUG DISPENSING PRACTICES

U. S. DISTRICT COURT
DISTRICT OF OREGON
FILED
Jan. 2, 1974
ROBERT M. CHRIST, Clerk

* * *

I, HOWARD STEINBACH, being first duly sworn, depose and say:

1. I am a registered pharmacist licensed by the State of Oregon, a partner in the operation of three pharmacies in the metropolitan area of Portland, including the Bel Aire Pharmacy, 12020 S. W. Allen Avenue, Beaverton, Oregon 97005, an assignor in the above-entitled cause, have attended various of the drug practices depositions taken by plaintiff, am familiar with the trial court file in this cause, make this affidavit on my personal knowledge, and make this affidavit pursuant to Rule 56, F.R. Civ.P., in support of plaintiff's Second Cause of Action.

2. This affidavit is submitted in support of plaintiff's position that drug dispensing to outpatients and others by alleged "non-profit" hospitals was outside the "for their own use" exemption contemplated by the Congress when it enacted the 15 U.S.C. § 13c exemption to the Robinson-Patman Act.

3. I know of my own personal knowledge that defendants objected to plaintiff's efforts to make discovery for the period prior to the four years preceding the filing of the complaint.

4. I know of my own personal knowledge that defendants did not offer any evidence of dispensing practices of alleged "non-profit" hospitals in 1938, the year the Congress enacted the 15 U.S.C. § 13c exemption to the Robinson-Patman Act.

5. About 1959 I was employed for some six months as a hospital pharmacist by Good Samaritan Hospital, Portland, Oregon, an alleged "non-profit" hospital. In that capacity I was personally familiar with the drug dispensing practices and policies of said hospital.

6. During my employment, Good Samaritan Hospital:

(a) Refused to fill outpatient prescriptions;

(b) Refused to fill "take-home" prescriptions for use outside the hospital;

(c) Refused to fill prescriptions for emergency room patients not admitted to the hospital;

(d) Refused to fill prescriptions submitted by hospital volunteers;

(e) Discouraged and made difficult the filling of prescriptions submitted by physicians for their personal use;

(f) Discouraged and made difficult the filling of

prescriptions submitted by hospital staff employees;

(g) Made an exception to the above-listed practices and policies only for emergency or exceptional drugs not available in retail pharmacies;

(h) Did not, to my personal knowledge, sell drugs to physicians for their office use.

7. Exhibit A to this affidavit is the cover page and pages 93, 94 and 95 of Rorer and Fishelis, *The Costs of Medicines*, University of Chicago Press, 1932. The study dealt with the manufacture and distribution of drugs and medicines in the United States and the services of pharmacy in medical care, and was the most extensive study of its kind as of 1932.

8. Exhibit A, *The Costs of Medicines*, does not even mention hospital outpatient or general public dispensing in its discussion of hospital drug purchases and practices. Instead, the report indicates that as of 1932 virtually all hospitals were not equipped or staffed to dispense prescription drugs for use outside the hospital. The hospital does not need a pharmacist generally to dispense drugs to hospital patients, but needs a licensed pharmacist if it sells drugs for use outside the hospital to outpatients, staff and members of the public. Page 94 of *The Costs of Medicines* states:

> ". . . Probably not more than 1,500 of the 7,000 hospitals in the United States employ

the full-time services of one or more licensed pharmacists."

9. Exhibit B to this affidavit is the cover page and pages 6-8, 117-120 and 169 of Francke, Latiolais, Francke and Ho, *Mirror to Hospital Pharmacy*, American Society of Hospital Pharmacists, 1964. The comprehensive volume is a report of the audit of pharmaceutical services in hospitals. The study was financed by the U. S. Public Health Service.

10. Page 169 of *Mirror to Hospital Pharmacy* states in effect that as late as 1964 less than one-half of the some 7,000 hospitals had pharmacists who could issue prescriptions to nonpatients:

> "Almost 4700 of the approximately 7000 hospitals in the United States lack the services of a full-time pharmacist. . . ."

11. Your affiant believes that *Mirror to Hospital Pharmacy* does not contain statistical material prior to 1957 relating to outpatient or nonpatient dispensing because the practice had not become a significant factor until approximately that time. For similar reasons the study did not attempt to elicit information as to the number of hospitals which sell drugs to the general public, for as stated at pages 6 and 7:

> ". . . But the number of hospitals supplying this type of service is thought to be quite small. Most of the prescriptions furnished by hospitals to private pay patients are undoubtedly furnished to patients of a physician who is a member of the hospital staff."

12. Exhibit C to this affidavit is the cover page

and pages 72-73 of the Task Force on Prescription Drugs, *The Drug Makers and The Drug Distributors*, U. S. Department of Health, Education, and Welfare, 1968. Exhibit C at page 72 states:

> "A large number of hospitals apparently do not employ full-time hospital pharmacists, although there are wide discrepancies in the data. . . ."

13. Exhibit C at page 73 noted the growth of hospital outpatient prescriptions:

> "In 1965, hospitals dispensed 8.9 percent of all outpatient prescriptions, up from 7.0 percent in 1962. . . ."

14. After reviewing the traditional services of hospitals, Exhibit C at page 72 states:

> "Many hospitals now provide outpatient prescriptions services through the hospital pharmacy. . . .
>
> "When providing outpatient services, hospital pharmacies compete with other community pharmacies and other vendors for the community prescription drug dollar. . . ."

15. The above-quoted excerpts reflect the fact that outpatient and nonpatient drug dispensing was virtually unknown in 1932 and only came to attention in the 1950's and 1960's, which were of course considerably later than 1938, the year the Congress enacted the 15 U.S.C. § 13c "for their own use" exemption to the Robinson-Patman Act.

16. I certify that Exhibit A, Exhibit B and Exhibit C are true, full and correct copies of said docu-

ments, are in context and are considered authoritative in the pharmacy profession.

• • •

APPENDIX IX

PLANTIFF'S R. FRANKLIN HART AFFIDAVIT RE HOSPITAL DRUG DISPENSING PRACTICES

U. S. DISTRICT COURT
DISTRICT OF OREGON
FILED
Jan. 9, 1974
ROBERT M. CHRIST, Clerk

• • •

I, R. FRANKLIN HART, being first duly sworn, depose and say:

1. I am a registered pharmacist licensed by the State of Oregon, reside at 3815 S. W. 54th Place, Portland, Oregon 97221, am employed on a part-time basis as a hospital pharmacist by Portland Adventist Hospital, am competent to make this affidavit, make this affivadit on my personal knowledge, and make this affidavit pursuant to Rule 56, F.R.Civ.P., on behalf of plaintiff in connection with plaintiff's Second Cause of Action.

2. Between 1935 and 1939, I was an employee of Blumauer-Frank Wholesale Drug Company, Portland, Oregon, and its purchaser, McKesson & Robbins Drug Company. In that capacity I regularly called on hospitals and other drug purchasers in the Yakima area of eastern Washington.

3. For a period of some 27 years, ending with my retirement in 1966, I was an employee of E. R. Squibb & Sons, Inc. During most of my employment as a Squibb representative, I regularly visited hospitals

and other drug purchasers in the metropolitan area of Portland, Oregon.

4. In 1941 I regularly visited hospitals and other drug purchasers in the Everett and Bellingham area of western Washington.

5. Between 1955 and 1960 I was a hospital specialist for Squibb. In that capacity I regularly called on nonprofit and other hospitals in the Pacific Northwest states.

6. These regular visits, during which I conferred with hospital pharmacists and observed their operations, gave me personal knowledge of the hospital pharmacy practices of the hospitals I visited.

7. Prior to the end of World War II, the private and nonprofit hospitals in the Portland and other areas of the Pacific Northwest I regularly visited did not sell drugs to outpatients or "walk-in" members of the public, but limited their drug dispensing to emergency room and hospitalized inpatients. The hospitals during that period generally had but one pharmacist, and his time was more than fully occupied filling drug orders for hospitalized inpatients.

8. It was not until some time after the end of World War II that the hospitals I regularly visited began to have more than one hospital pharmacist and for some of the hospitals to fill prescriptions for outpatients and others.

9. The post-war practice of filling prescriptions for outpatients and others, as distinct from limiting

drug dispensing to hospitalized inpatients,, was not noticeable to me until after 1960.

• • •

APPENDIX X

STANLEY E. HARTMAN AFFIDAVIT RE FIRST YEAR THAT PORTLAND AREA "NON-PROFIT" HOSPITALS APPLIED FOR PHARMACY LICENSES

U. S. DISTRICT COURT
DISTRICT OF OREGON
FILED
Jan. 11, 1974
ROBERT M. CHRIST, Clerk

* * *

I, Stanley E. Hartman, being first duly sworn, depose and say:

1. I am a registered pharmacist licensed by the State of Oregon, am engaged in the practice of pharmacy as a community pharmacist, am a member of plaintiff, Portland Retail Druggists Association, Inc., am an officer of one of the assignors herein, am competent to make this affidavit, make this affidavit on my personal knowledge, and make this affidavit in support of plaintiff's Second Cause of Action.

2. Since the State of Oregon first commenced regulation of pharmacies in 1891, a pharmacy license has been required to issue a prescription drug in the State of Oregon.

3. Under Oregon law a hospital, non-profit or otherwise, is required to have a pharmacy license only when and if it distributes prescription drugs to persons who are other than hospitalized inpatients.

The reason is that hospitalized inpatients and emergency ward patients receive hospital drug orders, and such orders do not require a prescription. If a drug is to be consumed by a person who is not hospitalized or receiving emergency room treatment, the drug is issued in the form of the prescription required by law. In other words, not until a hospital begins to dispense prescriptions, as contrasted to hospital drug orders, must the hospital apply for a pharmacy license under state law.

4. A Second Cause of Action issue is the intent of the Congress when in the year 1938 it enacted the 15 U.S.C. § 13c "for their own use" exemption to the Robinson-Patman Act, 15 U.S.C. § 13, et seq.

5. Plaintiff has made part of the trial court file two affidavits that indicate that, in general, "non-profit" hospitals did not distribute drugs to nonpatients when the 15 U.S.C. § 13c exemption was enacted in 1938.

* * *

7. Evidence in the form of state documents that tend to support the above-identified Steinbach and Hart affidavits are Exhibit A to this affidavit. Exhibit A consists of the initial pharmacy license applications of 13 alleged "non-profit" hospitals in the Portland area that compete in the retail sale of drugs with plaintiff's assignors and other community pharmacies in Multnomah, Clackamas and Washington counties, Oregon. The Exhibit A documents reflect on their face the exact date the application was received

and the number of the license.

8. The hospital does not submit a new application for renewal of its pharmacy license. Instead, the hospital submits a routine renewal application that is identified as such.

9. The State Board of Pharmacy is an agency of the State of Oregon with offices in the State Office Building, Portland, Oregon 97201. The board maintains Exhibit A documents and other documents relating to inspection of hospital pharmacies in the regular course of business as public records open to inspection and copying.

10. The Exhibit A documents were copied from the originals thereof at plaintiff's request as public documents and were made available to plaintiff by A. G. "Mike" McLain, the board's Secretary-Treasurer and custodian of said documents.

11. I certify that the Exhibit A documents to this affidavit are true, full and complete copies of the originals in the files of the State Baord of Pharmacy.

12. Selected from a larger number of documents were the initial pharmacy applications of 13 of the 14 alleged "non-profit" hospitals in Multnomah, Clackamas and Washington counties, Oregon that now compete for retail drug business in competition with plaintiff's assignors and other community pharmacies in the said three counties. Not reproduced is the application of the 14th hospital, Dwyer Memorial Hospital, which was organized in the 1960's.

13. A number of the hospitals whose license applications are reproduced in Exhibit A hereto were in business prior to World War II. Good Samaritan Hospital, for example, was organized in 1871, more than one century ago. This factor is noted because even the hospitals in existence prior to World War II did not make their application until after the end of that war.

14. Summarized below from the Exhibit A documents by "non-profit" hospitals is the date of initial application for a pharmacy license:

(1)	Emanuel Hospital	January 12, 1946
(2)	Good Samaritan Hospital	December 22, 1945
(3)	Gresham General Hospital	July 29, 1959
(4)	Holladay Park Hospital	December 11, 1959
(5)	Kaiser Hospital	June 16, 1959
(6)	Portland Osteopathic Hospital	October 30, 1952
(7)	Physicians and Surgeons Hospital	May 3, 1948
(8)	Portland Sanitarium & Hospital (Portland Adventist Hospital)	June 13, 1967
(9)	Providence Hospital	December 29, 1945
(10)	St. Vincent's Hospital	January 2, 1946
(11)	Tuality Community Hospital	August 15, 1969
(12)	Willamette Falls Community Hospital	June 16, 1970
(13)	Willamette View Manor Hospital	August 1, 1958

15. It is apparent that the first license issued to any of the 13 alleged "non-profit" hospitals to dispense prescriptions is dated some seven years after the enactment in 1938 of the 15 U.S.C. § 13c exemption to the Robinson-Patman Act.

• • •

APPENDIX XI

**LEGAL
OAH / LABOR AND
LEGISLATIVE LETTER**

Oregon Association of Hospitals · 220 S. W. Morrison
Portland, Oregon 97204 · 228-5608

No. 23 January 15, 1975

IMPORTANT

Your hospital should, from date of your receipt of this letter, refrain from making sales of your hospital drugs to the categories listed herein on page 2 items 3 through 8 inclusive.

FAR-REACHING FEDERAL COURT OPINION RESTRICTING HOSPITALS' RESALE OF DRUGS

The U. S. Court of Appeals for the Ninth Circuit on December 26, 1974 reversed a judgment of the Federal District Court in Portland in the suit of 64 retail druggists in the Portland-Tri-County area brought against 12 national drug manufacturers charging violation of the Federal Robinson-Patman Act, which prohibits a seller to discriminate in the charges made to different purchasers of their products when in so doing the result would be to lessen competition or attempt to create a monopoly in any line of commerce or to injure, destroy or prevent competition. (It is likewise unlawful for a purchaser to knowingly receive the benefit of such discrimination.)

The plaintiff had alleged that in making "use" of the drugs purchased by non-profit hospitals such drugs were not used exclusively for the hospital and that the defendants sold their products to hospitals at a lower price than charged the plaintiff retail druggists.

Section 13(c) (sic) of the Act exempts charities and nonprofit hospitals from the jurisdiction of the Act. The opinion holds that the exemption applied only when the nonprofit hospital uses the subject drugs for its "own use" and that its "own use" is limited to use by *in-patients* and "in the course of treatment to patients at emergency clinics operated by the hospitals."

Defendant manufacturers indicated that as to 14 hospitals in the Portland area the drugs involved were put to the following uses:

1. They were dispensed to the hospitals' in-patients in the course of treatment.
2. They were dispensed in the course of treatment to patients at emergency clinics operated by the hospitals.
3. They were provided to departing in-patients as take-home prescriptions.
4. They were provided to persons who had been in-patients as renewals of prescriptions which had first been filled while those persons were in-patients.
5. They were sold for home treatment to out-patients either at hospital pharmacies or at out-patient clinics.

6. They were sold to the hospitals' employees and students or the private use of purchasers.
7. They were sold to hospitals' physicians for their personal or family use or for dispensation in the course of their private practice.
8. They were sold to walk-in customers who were not hospital patients.

• • •

James G. Swindells
Associate Director and Legal Counsel

APPENDIX XII

AMERICAN SOCIETY OF HOSPITAL PHARMACISTS RESOLUTION

American Society of Hospital Pharmacists

House of Delegates

Grand Ballroom, St. Francis Hotel
San Francisco, California
April 23, 1975

Inaugural Address of the President
Fred M. Eckel

". . . Redeeming the Time"

* * *

And while on the subject of drug prices, a word must be said about the "Portland case" involving differential pricing of drugs sold to hospitals.

Certainly, this case raises difficult questions for hospital pharmacists.

At its March meeting, your Board of Directors discussed the Portland case and the underlying principle of preferential pricing at length and reached a consensus opinion which we have expressed as follows:

"The American Society of Hospital Pharmacists:

(1) opposes in principle the preferential pricing of drugs except when based on volume discounts that are available to all purchasers;

(2) believes that noninstitutional purchasers should enjoy the same prices now available to many institutional purchasers;

(3) opposes any action which would increase the price of drugs to any part of the consuming public.

In developing a posture on this situation, we must keep foremost in our minds the overall public interest. . . ."

Supreme Court, U. S.
FILED
MAY 12 1975
MICHAEL RODAK, JR., CLERK

No. 74-1274

In the Supreme Court
of the United States

OCTOBER TERM, 1974

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent,

v.

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners.

REPLY BRIEF IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

(Counsel for Petitioners are identified on the reverse side)

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No. 74-1274

In the Supreme Court
of the United States

OCTOBER TERM, 1974

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

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ABBOTT LABORATORIES, an Illinois corporation, et al,

Petitioners.

REPLY BRIEF IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

ARGUMENT

1. The Court of Appeals held and respondent contends that the Nonprofit Institutions Act, as applied to hospitals, exempts from the Robinson-Patman Act only purchases of drugs which are dispensed in sales to a "captive market" consisting of inpatients and emergency room patients, which retail druggists cannot supply. The odd result is to exempt only two kinds of drug purchases which, by their nature, cannot impair competition or violate the Robinson-Patman Act, and to deter hospitals from dispensing drugs in ways which the Court of Appeals admits are proper hospital drug

uses. Such a construction of the statute denies it substantive effect and is contrary to the public interest. It cannot possibly withstand review by this Court.

2. Respondent misconceives the issue tendered by the petition. The decision of the Court of Appeals limits the statutory exemption *as a matter of law* to drugs dispensed to inpatients and to patients in the emergency room, and excludes from the exemption, also as a matter of law, three important drug uses which are the subject of the petition and which are essential to modern hospital services. Marginal hospital drug uses, including those referred to by respondent (Res. Br. 8), were not made subjects of the petition.*

3. The decision of the Court of Appeals does not depend upon the "intended" use of the drugs at the time of purchase (see Res. Br. 21); the essential fact is that they are used, like drugs dispensed in sales to inpatients and in the emergency room, to fill the needs of the hospital in providing its services to the community.

4. Respondent errs in suggesting (Res. Br. 10, 23-24) that the legal issue presented by the Court of Appeals' decision was not the subject of thorough discovery. The Court of Appeals accepted the record as

* Petitioners do not, of course, accept respondent's exaggerated characterization of the record; see, e.g., Res. Br. 23. The Court of Appeals conceded that "by far the greater part of hospital drug distribution" is within the exemption, even under its narrow construction of the Nonprofit Institutions Act (App. A6). The record shows that such use approaches 90 percent.

sufficient to decide that issue, and its sufficiency was conclusively established by respondent itself in its ill-tempered objection in this Court to the motion of American Hospital Association for leave to file a brief *amicus curiae*. In its objection, respondent complains that AHA's motion and brief:

> ". . . assume the record was incomplete when, in fact, the record was extensive, i.e., some 50 depositions and thousands of pages of exhibits, and more than adequate for the issues decided." (Objection, p. 2).

We agree: The issue before the Court is fully developed in the record, and there is no reason to delay the urgently-needed review of the decision of the Court of Appeals.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

JAMES H. CLARKE
Counsel for Petitioner Eli Lilly and Company
FREDERIC A. YERKE
Counsel for Petitioner Abbott Laboratories
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Counsel for Petitioner Bristol-Myers Company
WALTER J. COSGRAVE
Counsel for Petitioner Carter-Wallace, Inc.
JACK L. KENNEDY
Counsel for Petitioner Endo Laboratories, Inc.
THOMAS M. TRIPLETT
Counsel for Petitioners Ortho Pharmaceutical Corporation and Warner-Lambert Pharmaceutical Company
ROBERT R. CARNEY
Counsel for Petitioners Squibb Corporation and E. R. Squibb & Sons, Inc.
ALLAN HART
Counsel for Petitioner A. H. Robins Company, Incorporated
BARNES H. ELLIS
Counsel for Petitioner William H. Rorer, Inc.

May 9, 1975

Supreme Court, U. S.
FILED
MAY 16 1975
MICHAEL RODAK, JR., CLERK

In the Supreme Court

of the United States

OCTOBER TERM, 1974

No. 74-1274

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,

Respondent,

v.

ABBOTT LABORATORIES, et al,

Petitioners.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY BRIEF FOR RESPONDENT IN OPPOSITION

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No. 74-1274

IN THE SUPREME COURT

OF THE UNITED STATES

October Term, 1974

PORTLAND RETAIL DRUGGISTS
ASSOCIATION, INC.,

Respondent,

v.

ABBOTT LABORATORIES, et al,

Petitioners.

-

REPLY BRIEF FOR RESPONDENT IN OPPOSITION

-

Argument

-

Petitioners' reply brief concedes the validity of much of the challenged Ninth Circuit decision.

Little remains for this Court to decide.

Petitioners concede that they do not appeal the decision that the following

commercial drug sales are outside of the 15 U.S.C. § 13c exemption:

1. Drug sales to "walk-in" members of the general public, all for use off the hospital premises by individuals not hospital patients;
2. Drug sales to physicals for their private office use;
3. Drug sales to hospital volunteers;
4. Drug sales to <u>families</u> of hospital employees, physicians and volunteers.

Petitioners apparently do not challenge Respondent's citations or the contents of its Appendix.

There is no evidence that the decision, and Petitioners cite none, will "deter" hospital drug dispensing.

Because Respondent was denied discovery of evidence in Petitioners'

exclusive possession (the reason the extensive record is incomplete, disputed and not ripe for appellate review), it cannot accept Petitioners' page 2 estimate that exempt drug sales "approaches 90 percent."

Assuming <u>arguendo</u> the estimate is correct, some 90 per cent of hospital drug purchases will continue to receive the 15 U.S.C. § 13c exemption.

Petitioners claim that the remaining 10 per cent drug sales are "marginal."

The decision held as to the drug sales outside the exemption:

> " * * * The question is not whether the hospitals can continue to provide this useful community service. The question is whether in providing it they may acquire the drugs for such resale at an acquisition price that discriminates against local retail druggists. We hold that they may not." (Pet. A7)

The alleged "non-profit" hospitals can continue under the decision to make the arguendo 10 per cent commercial drug sales outside the 15 U.S.C. § 13c exemption without hindrance or interference.

Respondent has no quarrel with such sales, provided all competitors receive an even break.

The arguendo 10 per cent "marginal" drug sales that are the subject of the petition does not warrant granting of certiorari.

Conclusion

The petition should be denied.

Respectfully submitted,

ROGER TILBURY
HENRY KANE

May 14, 1975.

MOTION FILED

APR 14 '975

IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-1274

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,

Respondent,

—v.—

ABBOTT LABORATORIES, *et al.*,

Petitioners.

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF FOR AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-1274

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,

Respondent,

—v.—

ABBOTT LABORATORIES, *et al.*,

Petitioners.

MOTION OF THE AMERICAN HOSPITAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE*

Pursuant to Rule 42 of the Rules of this Court, the American Hospital Association hereby respectfully moves this Court for leave to file the attached brief *amicus curiae* in the above-captioned case. The brief is in support of the petition for a writ of certiorari to the United States Court of Appeals for the Ninth Circuit.

Counsel for the petitioners have consented to the filing of the attached brief. Counsel for the respondent have not consented to its filing.

The American Hospital Association

The American Hospital Association ("AHA") is a non-profit organization which represents some 7,500 institutional members (hospitals and other health care institutions) and more than 16,000 personal members. The purpose of the AHA is stated in its first bylaw:

> "[The AHA] object shall be to promote the welfare of the public through its leadership and its assistance to its members in the provision of better health care services for all the people."

The organization's principal interest is the care which patients receive from the hospitals of this country.

AHA provides a wide range of professional services in order to develop "better health services for all the people." It, along with the American College of Surgeons, the American College of Physicians, and the American Medical Association, is a sponsor of the Joint Commission on Accreditation of Hospitals, an organization which assists hospitals in their efforts to provide optimal levels of care. AHA conducts a considerable number of educational programs, such as workshops, institutes and meetings, to assist its members in providing efficient hospital care. It publishes and distributes substantial amounts of professional literature on the same subject. AHA conducts the most extensive data collection program in the hospital field and a wide range of hospital research projects.

AHA also represents its membership with respect to governmental matters before the Congress and such federal agencies as the Department of Health, Education and Welfare.

The Interest of the American Hospital Association as *Amicus Curiae*

The decision of the Court of Appeals for the Ninth Circuit is of profound significance to all nonprofit hospitals and the AHA. It is the first judicial application of the Nonprofit Institutions Act to hospitals. It has massive precedential consequences. The decision attempts to list every type of drug use by nonprofit hospitals and then to

determine, in broad and absolute terms, the application of the Act's Robinson-Patman exemption to each type of drug use. This is not a decision limited to a particular type of drug usage by a particular type of nonprofit hospital. The decision threatens to affect all nonprofit hospitals, not just in the Ninth Circuit, but all across the nation.

Yet it is the nonprofit hospitals whose interests have not been represented in the prior proceedings in this action. With all respect to the respondent assignee of various retail druggists, and to the petitioner drug manufacturers, it is the nonprofit hospitals represented by AHA that would feel the real brunt of the decision.

The Nonprofit Institutions Act was enacted to confer important benefits upon nonprofit hospitals, namely, the opportunity to purchase drugs and other supplies at special low prices so as to enable the hospitals to operate as inexpensively as possible. It is surely appropriate that the AHA be given the opportunity to convey to the Court its views with respect to the application of this important exemption to nonprofit hospitals.

The AHA believes that the decision is fundamentally unsound. It is inherently illogical. It relies on a rigid, categorical approach to determine which drugs are purchased for a hospital's "own use" and thereby qualify for the exemption, and which drugs do not qualify for the exemption even though they are used to treat sick people in the performance of admittedly proper hospital functions. The eight listed categories do not even cover the present range of hospital drug usage. And the arbitrary line of demarcation between exempt and nonexempt categories is never explained; it is in fact inexplicable.

The practical consequences of compliance with the decision would be enormous and costly. No matter how the

decision were implemented, it would result in higher drug costs, higher administrative costs and substantial disruption of services and supply procedures.

The AHA further believes that the decision of the Court of Appeals is premised on an inaccurate understanding of the functions of a hospital in contemporary society. Public and private health care experts, the Congress, and the federal health care agencies agree that the present gap in health care services can only be narrowed if the hospital becomes the primary source for total community health services. The decision is flatly inconsistent with the ongoing expansion of outpatient and ambulatory services by hospitals—a vital development in the delivery of health care in this country.

The AHA wishes to bring to the Court's attention these developments in hospital care and the experience and views of the nonprofit hospitals who would be affected by this decision most directly.

Accordingly, the American Hospital Association respectfully urges this Court to grant its motion for leave to file its brief as *amicus curiae*.

Respectfully submitted,

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S. Rep. No. 1769, 75th Cong., 2d Sess. (1938) 7

Other Authorities:

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Bodenheimer, *Patterns of American Ambulatory Care*, VII Inquiry 26 (September 1970) 9

Clarke, *Medications for Outpatients*, 20 Hospitals 60 (September 1946) 8

Department of Health, Education, and Welfare, A Report to the President on Medical Care Prices (1967) 14

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Martin, *Control of Out-Patient Service and Charges*, Hospitals at 85 (September 1942) 8

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National Advisory Commission on Health Facilities, A Report to the President (1968) 14

Perkoff and Anderson, *Relationship Between Demographic Characteristics, Patient's Chief Complaint, and Medical Care Destination in an Emergency Room*, VIII Medical Care 309 (1970) 9

H.M. and A.R. Somers, Medicare and the Hospitals—Issues and Prospects (1967) 14

IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-1274

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,

Respondent,

—v.—

ABBOTT LABORATORIES, *et al.*,

Petitioners.

BRIEF FOR AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

Interest of *Amicus Curiae*

The interest of the American Hospital Association as *amicus curiae* is set forth in the preceding motion for leave to file this brief.

Question Presented

Is the Nonprofit Institutions Act exemption for drugs purchased by nonprofit hospitals "for their own use" limited solely to drugs dispensed to inpatients and patients in the emergency clinic?

Statement of the Case

1. *The Proceedings Below*

Respondent, as the assignee of claims from sixty retail pharmacies, filed this action against twelve drug manufacturers seeking treble damages and injunctive relief. Respondent alleged, *inter alia,* that petitioners had engaged in unlawful price discrimination in violation of the Robinson-Patman Act, 15 U.S.C. §13 *et seq.,* by selling drugs to nonprofit hospitals at prices lower than those offered to commercial retail pharmacies.

Petitioners moved for summary judgment on this claim on the ground that the Nonprofit Institutions Act, 15 U.S.C. §13c, exempts drug purchases by nonprofit hospitals from the application of the Robinson-Patman Act. The District Court agreed and granted petitioners' summary judgment motion on May 25, 1973. (Petitioners' Appendix B) The Court of Appeals for the Ninth Circuit, however, disagreed and vacated the judgment of the District Court on December 26, 1974. (Petitioners' Appendix A) The drug manufacturers thereafter filed a petition for rehearing, and the American Hospital Association sought to file a brief in support of their petition. On March 11, 1975, the Court of Appeals denied both the petition for rehearing and AHA's motion for leave to file its brief as *amicus curiae.* (Petitioners' Appendix C)

2. *The Decision of the Court of Appeals*

The Court of Appeals vacated the judgment below because it interpreted the scope of the Nonprofit Institutions Act ("the Act" or "Section 13c") more narrowly than the

District Court. The issue, as framed by the Court of Appeals, was whether each of eight categories of drugs purchased by hospitals was "for their own use" within the meaning of Section 13c. The appellate court concluded that only two categories—drugs dispensed to inpatients and to emergency clinic patients—were for the hospitals' "own use," and hence covered by the Section 13c exemption to the Robinson-Patman Act. The court conceded that the remaining six categories, including dispensation of drugs to outpatients at outpatient clinics, to departing inpatients as take-home prescriptions, and to other patients and users of medication, were "a proper and useful community service and thus can be regarded as a proper hospital function." (Petitioners' Appendix at A7) But the court held without explanation that such uses were not the hospitals' "own use" and therefore did not qualify for the Section 13c exemption:

> "Hospital use under §13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of in-patients or emergency patients. The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer." (Petitioners' Appendix at A7)

ARGUMENT

The instant case presents an extremely "important question of federal law which has not been, but should be, settled" by this Court:[1] whether the Nonprofit Institutions Act exemption for drugs purchased by nonprofit hospitals is limited solely to *horizontal* drug usage, that is, to drugs dispensed to inpatients and emergency clinic patients, and is inapplicable to *vertical* drug usage, that is, to drugs dispensed in outpatient clinics and in the course of other admittedly proper hospital functions.

The Court of Appeals for the Ninth Circuit has summarily concluded that only drugs dispensed to inpatients and emergency clinic patients qualify for the Robinson-Patman Act exemption, that all other uses of medications by hospitals are not "for their own use."

The ramifications of this extraordinary holding are enormous. It will boost the already high cost of medical care still higher. It will create a host of practical difficulties for the nation's hospitals. And it will hamper a vital development in the delivery of health care services—the expansion of outpatient and ambulatory services.

The impact of this decision will not be limited to the nation's hospitals and the patients whom they serve. All across the country, schools, colleges, universities, public libraries, churches and other charitable institutions, and their suppliers, will regard this decision as the authoritative interpretation of the Nonprofit Institutions Act. The Ninth Circuit's extraordinarily narrow interpretation will frustrate the beneficient purposes of the Act for all nonprofit institutions.

[1] Supreme Court Rule 19.

The decision is clearly wrong. It is based on an improper method of statutory construction. It relies on a rigid, categorical approach to drug use by hospitals which is illogical and inherently unworkable. The distinctions among the categories are indefensible. The arbitrary line of demarcation between the exempt categories and nonexempt categories is never explained.

The Ninth Circuit has cut back considerably on the benefits conferred by the Congress. Moreover, its exceedingly narrow reading of the Section 13c exemption has created uncertainty about the legality of all discounts granted to nonprofit institutions; the inevitable effect will be the erosion of Section 13c benefits.

In view of the enormous consequences of this erroneous decision for hospitals, schools, colleges, universities, public libraries, churches and charitable institutions, their suppliers, and the public, *amicus* respectfully urges that certiorari be granted.

I.

The Decision Presents an Important Question of Federal Law Which Has Not Been But Should Be Settled by This Court.

The Ninth Circuit decision propounds new law of profound precedential scope. The Nonprofit Institutions Act has been the subject of only one other judicial decision since its enactment in 1938. In that other decision, *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212, *cert. denied*, 389 U.S. 898 (1967), the Ninth Circuit interpreted the Act in broad and sympathetic fashion.[1] In the instant decision, the Ninth

[1] The Section 13c exemption was also mentioned in a footnote in *Students Book Co.* v. *Washington Law Book Co.*, 232 F.2d 49, 50-51 n.5 (D.C. Cir. 1955), *cert. denied*, 350 U.S. 988 (1956).

Circuit has interpreted the Act in narrow, radically different fashion. The decision, as the only current interpretation of Section 13c from any court in the land, promises to affect every beneficiary of the statute—every hospital, school, college, university, public library, church and charitable institution across the nation—and the suppliers of these institutions.

In the hospital field alone, the decision involves a federal question of considerable importance. The Court of Appeals has promulgated not a decision, but a doctrine. The opinion does not merely determine the applicability of the Section 13c exemption to a particular drug sale, or a particular hospital, in particular factual circumstances. Instead, the decision attempts to identify every type of drug use by hospitals, and to grant or deny the Section 13c exemption to each identified type of use in absolute, categorical fashion.

We do not, however, urge the Court to grant certiorari simply because the decision below determines an important federal question. We respectfully submit that the Ninth Circuit has decided this important federal question incorrectly. Unless the Court agrees to review the decision, the nonprofit institutions of this nation, their suppliers, and the public, will be left vulnerable to its adverse impact.

The Decision Is an Anachronism

The decision of the Court of Appeals is incompatible with the functions of a hospital in contemporary society. It holds that the Section 13c exemption, permitting special, low prices to nonprofit hospitals, should be confined to the principal activities performed by hospitals nearly 40 years ago. Without reference to the realities of modern-day practice, the Court of Appeals has determined that only drugs provided by hospitals to inpatients and emergency clinic patients may be said to have been purchased by the hospital for its "own use," within the meaning of Section 13c. All other hospital uses of drugs and other hospital supplies—such as drugs used by hospitals in treating outpatients—though conceded to be "proper hospital function[s]" are nevertheless held to be outside the scope of the exemption.

This frozen definition of a hospital's "own use" of drugs is inconsistent with the broad beneficent purposes of the statutory exemption. The legislative history of the Nonprofit Institutions Act makes clear that the purpose and justification for the exemption lay in the nonprofit character of the beneficiary institutions listed in the law, not in the particular activities of such institutions in 1938.[1]

Congress intended to enable the listed nonprofit institutions "to operate as inexpensively as possible."[2] Congress did not intend to limit a nonprofit institution's "own use" of supplies to those particular activities which schools,

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[1] H.R. Rep. No. 2161, 75th Cong., 2d Sess. (1938); S. Rep. No. 1769, 75th Cong., 2d Sess. (1938).

[2] *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212, 216 (5th Cir.), *cert. denied*, 389 U.S. 898 (1967).

libraries, churches and hospitals were in fact conducting on the date of enactment of Section 13c.[1] Such static statutory construction would substantially impair the ability of the beneficiary institutions to continue to operate inexpensively under the changed circumstances which inevitably come with the passage of time.[2]

If the beneficent purpose of the Act is to be realized, if public service institutions are to "operate inexpensively," as the Congress intended, the exemption must be coextensive with the present-day functions of the beneficiary institutions.

The Decision Draws Distinctions Which Are Arbitrary and Illusory

The decision holds that drugs are purchased for the hospital's "own use" and are entitled to the Section 13c exemption only when the drugs are consumed by persons lying in a horizontal position—in a hospital bed or in the emergency clinic. The drugs consumed by persons in a vertical position—upon discharge from the hospital or in an outpatient clinic—are denied the Section 13c exemption. This makes no sense.

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[1] Though not as predominant or important as they are today, outpatient departments were nevertheless an integral part of the hospital forty years ago. In 1941, one physician wrote, "It is almost superfluous to emphasize that the pharmacy and out-patient department are among the most essential services of a hospital." Merrill, *Hospital Pharmacy and Out-Patient Department*, Hospitals at 33 (June 1941). *See also*, Martin, *Control of Out-Patient Service and Charges*, Hospitals at 85 (September 1942); Clarke, *Medications for Outpatients*, 20 Hospitals 60 (September 1946).

[2] *See Eastern Kentucky Welfare Rights Organization, et al.* v. *Simon*, 507 F.2d 1278 (D.C. Cir. 1974).

Even if hospitals provided only inpatient care, this distinction would be arbitrary. But in light of the functions of a modern hospital—where outpatient care is an integral and growing part of hospital health care service—the distinction is absurd.

Hospitals necessarily use drugs in treating inpatients and outpatients. The hospital's use of drugs in treating inpatients and outpatients is identical. In neither case does the hospital "consume" the drug. In both cases it is the patient—inpatient or outpatient—who does so. In both cases the hospital is engaging in a "proper hospital function," as the Court of Appeals conceded. By what logic, then, can the Section 13c exemption be accorded to drugs used to treat inpatients but denied to drugs used to treat outpatients?

The decision confers the Section 13c exemption upon drugs used in the emergency clinic but denies the exemption to drugs used in the outpatient clinic. Yet study after study has shown that, in most urban hospitals, the emergency clinic serves for all practical purposes as an outpatient clinic.[1] On what rational basis, then, can it be determined that drugs provided to patients in the emergency clinic are for the hospital's "own use," whereas drugs provided to patients in a hospital outpatient clinic are not?

The rigid lines drawn between inpatients and outpatients, between emergency clinics and outpatient clinics, and between other exempt and nonexempt categories are nowhere explained in the decision.

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[1] Bodenheimer, *Patterns of American Ambulatory Care*, VII Inquiry 26, 33 (September 1970); Perkoff and Anderson, *Relationship Between Demographic Characteristics, Patient's Chief Complaint, and Medical Care Destination in an Emergency Room*, VIII Medical Care 309 (1970) and studies cited therein.

The Categorical Approach of the Court of Appeals Is Unworkable

Surely the availability of the exemption for drug purchases should not turn on where the sick person swallows his pill, or whether he takes his pill while lying down or standing up. The scope of the Section 13c exemption should be determined in entirely different fashion.

The controlling question should be the primary purpose of the purchase by the hospital: is it for the treatment of hospital patients or the performance of other legitimate hospital functions? If so, the Section 13c exemption should apply.

This functional approach to Section 13c was utilized, ironically, by the Ninth Circuit in *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967). In that case it was established that the "primary purpose" of the purchase of bowling alley equipment by a university was to "fulfill the needs" of that nonprofit institution; accordingly, the Court of Appeals ruled as a matter of law that the purchase was for the institution's "own use" and entitled to the Section 13c exemption. The court accepted without challenge the judgment of the institution as to how it should conduct its activities, finding it unnecessary to inquire into collateral uses of the purchased supplies.[1]

[1] The Internal Revenue Service has adopted a similarly sensible test for determining whether a hospital is engaging in an unrelated business through its sale of drugs to various persons. The IRS test is whether the drugs are sold to *patients* of the hospital. Inpatients, outpatients, discharged patients, patients receiving medical services as part of a home care program or in an extended care facility—all have been deemed to be "patients" of the hospital. Rev. Rul. 68-376, 1968-2 Cum. Bull. 246. The IRS test would work equally well in regard to Section 13c.

By contrast, the decision in the instant case would apparently require judicial scrutiny of all uses of all supplies purchased by nonprofit institutions. The categorical test would compel courts to separate out (1) uses for proper institutional purposes and (2) "for their own use" uses; only the latter would be entitled to the Section 13c exemption.

Such a test would flatly contradict the will of Congress. And it would create open-ended uncertainty among tens of thousands of nonprofit institutions, and their suppliers.

The Court should not abandon those who must live with this decision on a daily basis. Unless certiorari is granted, nonprofit institutions and their suppliers will not know where they stand with respect to Robinson-Patman Act exposure. Uncertainty regarding such liability may force suppliers to discontinue or modify their special low prices to nonprofit institutions, thereby frustrating the beneficent purposes of the Section 13c exemption. Nonprofit institutions themselves, fearful of Robinson-Patman liability, may be obliged to buy at higher commercial prices, to the detriment of the communities these institutions serve.

Section 13c would thus become a nullity.

II.

The Decision, If Not Reviewed by This Court, Will Have Serious Adverse Impact Upon Nonprofit Hospitals and the General Public.

If the Court does not review the decision at this time, nonprofit hospitals and those who receive and pay for hospital care will be immediately and adversely affected.

Adverse Consequences to Hospitals

Section 13c was intended to confer substantial benefits upon hospitals and other nonprofit institutions. The decision of the Court of Appeals, however, would convert Section 13c benefits into burdens of considerable consequence.

How would a hospital attempt to comply with the decision? We see only four possibilities, all of them objectionable:

(1) A hospital could set up and maintain dual inventories and distribution systems for drugs and other hospital supplies, one "for their own use" uses, and the other for other proper hospital uses. The substantial costs and burdens of a double inventory system are obvious. It would require duplication of all supply functions and procedures—requisitions, bidding processes, purchase orders, accounting records, inventory, storeroom space, personnel and so on—for the 1800 to 4500 different drugs and dosage forms typically stocked by a hospital pharmacy and for the many other supplies which hospitals purchase. The burden would be even greater in the large hospital which operates a number of separate pharmacies within the hospital in order to distribute drugs more effectively.

(2) Alternatively, a hospital might be obligated to trace the uses to which a single inventory of hospital pharmaceuticals or other supplies is put, subsequently securing a rebate for items allocated to "for their own use" uses, or paying a surcharge for items allocated to other proper purposes. This arrangement, however, would be an administrative nightmare. Keeping track of the use to which all hospital supplies are put would be an extraordinary undertaking in view of the quantity of drugs and other supplies stocked by the hospital. Moreover, hospitals obtain their supplies from a variety of sources—manufacturers, wholesalers, and combinations of both. Also, it is common for hospitals to purchase a single product from more than one supplier. It would be an extraordinary chore to determine which supplier owes a rebate to the hospital or is due a surcharge from the hospital.

(3) A hospital could simply pay higher prices for *all* of its prescription drugs and other supplies. This alternative would considerably increase the cost of hospital operations, which are already high, and inevitably result in higher hospital bills to hospital patients and the public.

(4) Finally, a hospital might, at least in theory, eliminate its "nonexempt" functions, *e.g.*, its outpatient clinic and ambulatory care services. Such a solution, however, would be completely contrary to vital current trends in health care. The hospital today occupies the central position in the health care system. It is no longer just an inpatient care facility; it is now a health center "encompassing and integrating the wide range of comprehensive

medical services—prevention, treatment, rehabilitation, and after-care."[1] The hospitals of this country have responded to the growing demand for more and better health care services by expanding their outpatient and ambulatory services. (Petitioners' Appendix D) The Federal Government has strongly supported the development.[2] Expansion of outpatient and ambulatory services is the only practical means for providing better health care to more people at lower cost. Only by the increased use of ambulatory facilities can the widening gap in the provision of health care services be narrowed and the exploding cost of health care be brought under control. Yet, the decision below would deny the Section 13c exemption to drugs (and presumably other supplies) used in such essential hospital operations.

The decision of the Court of Appeals, if allowed to stand, would thus confront nonprofit hospitals with a series of extraordinarily onerous and unacceptable alternatives.

More distressing, still, is the danger that drug manufacturers and other hospital suppliers may feel compelled by the decision to discontinue all Section 13c special low prices. Sellers may simply be unwilling to risk any Robinson-Patman exposure. Should suppliers take this course, the purpose of the Section 13c exemption will have been totally frustrated.

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[1] H.M. AND A.R. SOMERS, MEDICARE AND THE HOSPITALS—ISSUES AND PROSPECTS 43 (1967); *see also*, Editorial, *The Hospital's Responsibility for Primary Care*, 2 Hospital Medical Staff 1 (January 1973).

[2] *See generally*, NATIONAL ADVISORY COMMISSION ON HEALTH FACILITIES—A REPORT TO THE PRESIDENT (1968); DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, A REPORT TO THE PRESIDENT ON MEDICAL CARE PRICES (1967); National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 93d Cong., 2d Sess.; Public Health Service Amendments of 1968, Pub. L. No. 90-574, 82 Stat. 1005; Hill-Burton Amendment of 1970, 42 U.S.C. § 291c(a)(5).

Adverse Consequences to the Public

No matter which course the hospital and its suppliers might take as a result of the decision below, the impact upon the public would be the same: higher hospital costs. The cost of hospital care will inevitably rise if hospitals must maintain double inventories, or pay higher prices for their supplies, or incur needless additional administrative expenses, or lose Section 13c prices entirely.

The Government, and ultimately, the taxpayer would be obliged to pay more for hospital care. Medicaid costs, which cover outpatient prescription costs, would increase. The Government cost of financing various health programs administered by nonprofit hospitals—such as the migrant health program, 42 U.S.C. § 242(h), and the Indian health program, 42 U.S.C. § 2002—would also increase. Should Medicare be extended to cover outpatient prescriptions, the cost of that program would increase as well.

In fiscal year 1972-73, the Federal Government and the state governments spent $670 million for the drugs and drug sundries provided in connection with national health programs.[1] This amount would rise significantly if the Section 13c exemption were limited in the fashion prescribed by the Court of Appeals.

The extraordinary impact of this decision on the cost of health care alone surely warrants a grant of certiorari. When the impact of this decision is multiplied by all the nonprofit institutions serving communities across the nation, the urgency of Supreme Court review becomes all the more apparent.

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[1] 37 Soc. Sec. Bull. No. 2, Table 2, p. 7 (February 1974).

CONCLUSION

For the foregoing reasons, *amicus curiae* respectfully urges that this Court grant a writ of certiorari.

Respectfully submitted,

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In the Supreme Court

of the United States

OCTOBER TERM, 1974

No. 74-1274

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,

Respondent,

v.

ABBOTT LABORATORIES, et al,

Petitioners.

RESPONDENT'S OBJECTION TO AMERICAN HOSPITAL ASSOCIATION MOTION TO FILE BRIEF AND BRIEF AS AMICUS CURIAE IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

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Other Authorities

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Rule 42, U.S. Sup. Ct. 1

"Small Business Problems in the Drug Industry," House Select Committee on Small Business, House Report No. 1983, 90th Congress, 2d Session, Dec. 31, 1968, pp. 77-83 5

change, Inc., Dkt. 74-304. (U. S. Supreme Court Bulletin, B 650-651.)

Movant has no direct interest or standing.

Movant's motion and conditionally filed brief do not aid the Court, for they:

(a) beg the question;

(b) add nothing relevant to the record or argument not already advanced by petitioners;

(c) assume "facts" not in the record;

(d) rely on self-serving documents prepared by hospital advocates that are not in the record;

(e) rely on policy questions that should be addressed to the Congress, not the courts, and

(f) assume the record was incomplete when, in fact, the record was extensive, i.e., some 50 depositions and thousands of pages of exhibits, and more than adequate for the issues decided.

Contrary to movant's unsupported claim of harm or interference, the opinion does not interfere with any hospital function; a hospital may continue to dispense drugs to staff, employees, the "walk-in" general public, physicians for resale in their private office practice, and all categories of patients:

> ". . . The question is not whether the hospitals can continue to provide this useful community service. The question is whether in providing it they may acquire the drugs for such resale at an acquisition price that discriminates against local retail druggists. We hold that they may not." (Petitioners' Appendix at A7).

Movant errs in claiming at p. 3 of its motion that ". . . it is the 'nonprofit' hospitals whose interests have not been represented in the prior proceedings in this action.":

(a) The interests of petitioners and the interests of the "nonprofit" hospitals were and are identical — both desire to continue the challenged practices;

(b) Several of the "nonprofit" hospitals were represented at depositions taken by respondent by law firms that at the same time represented various of the petitioners;

(c) During the extensive depositions the hospitals were represented by counsel, including counsel for the Oregon Association of Hospitals, an apparent affiliate of movant, American Hospital;

(d) During the depositions the hospital witnesses presented without objection, much evidence in support of the challenged drug dispensing practices;

(e) At the District Court and Court of Appeals level the respondents asserted movant's position and arguments. See, for example, Petitioners' Appendix A6-A7.

Movant errs in implying that the "nonprofit hos-

pitals pass on to their patients the lower prices they receive from petitioners and some, but not all, drug manufacturers.

(a) There is no evidence in the trial court file that a patient (as distinct from a physician or employe) paid a lower hospital drug price because the hospital purchased the drug for less than the price to the competing retail pharmacy;

(b) The evidence is to the contrary.

(c) There is substantial, uncontradicted, evidence that the hospital patient paid the average, or above, price that a retail pharmacy would have charged for the same quantity and grade of drugs;

(d) In welfare cases the admitted evidence is that at least one hospital overcharged the Welfare Division of the State of Oregon for drugs to welfare patients;

(e) It is elementary that the "nonprofit" hospital pharmacies would have operated at about the break-even point if hospitals passed on to patients their lower drug acquisition costs;

(f) The admitted record shows that after all deductions from gross drug income, i.e., losses from operation of the hospital cafeteria, the hospitals reported net profits on drug sales of as high as 60 per cent:

> ". . . It was undisputed that the hospitals derived substantial profits from the sale of drugs and from time to time enjoyed over-all operating surpluses. . . ." (Petitioners' Appendix A3).

Movant makes the unsupported assumption that the decision means higher drug prices to "nonprofit" hospitals.

The assumption is pure speculation.

Movant ignores the perhaps equal possibility that drug firms will lower retail pharmacy prices to the "nonprofit" hospital level, and thus end their price discrimination.

Movant does not advise the Court that only some drug companies sell at discriminatory prices to "nonprofit" hospitals.

A number of drug companies sell their products to "nonprofit" hospitals and retail pharmacies at the same price.

Movant and its member hospitals have been on notice since 1968 that the House Small Business Committee concluded that certain hospital drug sales were outside the 15 U.S.C. § 13c exemption to the Robinson-Patman Act:

> "Small Business Problems in the Drug Industry," House Select Committee on Small Business, House Report No. 1983, 90th Congress, 2d Session. Dec. 31, 1968, pp. 77-83.

Movant and its member hospitals have been on notice since *Students Book Company* v. *Washington Law Book Company*, 232 F.2d 49 (D.C. Cir. 1955), cert. den., 350 U.S. 988, that certain sales were outside the 15 U.S.C. § 13c exemption:

> "5. . . . Although the appellee has sold books

> to all three of the universities for their own use, *i.e.*, for their libraries, the transactions here in question were not actually with the universities, but with the self-sustaining campus book stores, and *the books sold were not for the use of the universities, but for resale at a profit. The exemption provision is therefore inapplicable to these transactions.*" 232 F.2d at 50-51, fn. 5. (emphasis added).

Movant relies on the irrelevant ground that the Supreme Court should judicially enlarge the § 13c exemption because hospital drug dispensing practices have changed since § 13c was enacted in 1938.

Movant thus concedes that "nonprofit" hospitals engage in drug dispensing practices such hospitals did not engage in when § 13c was enacted.

Gulf Oil Corporation v. *Copp Paving Company, Inc.*, — U.S. —, 95 Sup. Ct. 392, 402 (1974) rejected judicial amendment:

> ". . . But whether it would justify radical expansion of the Clayton Act's scope beyond that which the statutory language defines—expansion, moreover, by judicial decision rather than amendatory legislation — is doubtful. . . ."

Movant's motion should be denied because it ignores the principle that a statute is construed as of the time of and with reference to the circumstances existing at the time of enactment:

> *United States* v. *Wise*, 370 U.S. 405, 411 (1962).
> *Civil Aeronautics Board* v. *Delta Air Lines, Inc.*, 367 U.S. 316, 323 (1961).
> *United States* v. *Champlin Rfg. Co.*, 341 U.S. 290, 297 (1951).

Movant relies on the irrelevant ground that the decision may be adverse to the economic interest of its members. Assuming *arguendo* such adverse impact, promotion of self-interest does not invoke the rule of reason to immunize otherwise illegal conduct in violation of the antitrust laws. *Otter Tail Power Company* v. *United States*, 410 U.S. 366, 380 (1973).

Assuming *arguendo* the possibility of an adverse effect, it is the legislative and not the judicial branch of the government from which relief should be sought. *Anchor Serum Company* v. *Federal Trade Commission*, 217 F.2d 867, 873 (7th Cir. 1954).

CONCLUSION

For the above reasons, the instant motion should be denied.

Respectfully submitted,

ROGER TILBURY
HENRY KANE

April 18, 1975.

Supreme Court, U. S.
FILED
AUG 4 1975
MICHAEL RODAK, JR., CLERK

No. 74-1274

In the Supreme Court

of the United States

OCTOBER TERM, 1974

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

PETITIONERS' BRIEF

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Better Hospital Care for the Ambulant Patient, Hospital Association of Pennsylvania, 1946, p. 2	23
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83 Cong. Rec. 6065 (1938)	18
Davis and Warner, Dispensaries, MacMillan, 1918, pp. 36, 74, 92-93, 187-189	23
Francke, Latiolais, Francks and Ho, Mirror to Hospital Pharmacy, American Society of Hospital Pharmacists, 1964, pp. 67-68, 117-120	25
House Report 2161, 75th Cong., 3d Sess. (1938)	17, 37
Knowles, John H., The Hospital, Scientific American, September 1973, pp. 128, 136	24
Merrill, "Hospital Pharmacy and Out-Patient Department," Hospitals, June 1941, p. 33	23
Patman, Complete Guide to the Robinson-Patman Act, (1963 ed.), pp. 7-10	19
Rowe, Price Discrimination Under the Robinson-Patman Act, (1962), pp. 3-23, 176	19
Senate Report 1769, 75th Cong., 3d Sess. (1938)	17, 18, 40
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In the Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-1274

ABBOTT LABORATORIES, an Illinois corporation, et al.,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITIONERS' BRIEF

OPINIONS BELOW

The oral opinion of the district court of May 25, 1973 granting petitioners' motion for partial summary judgment is not reported. The opinion of the Court of Appeals of December 26, 1974, vacating the judgment of the district court, is reported at 510 F.2d 486 and at 1974-2 Trade Cases ¶ 75,437.

JURISDICTION

The judgment of the Court of Appeals was entered on December 26, 1974. Petitioners filed a timely petition for rehearing and suggestion for rehearing in banc, which was denied on March 11, 1975. Petitioners filed a petition for certiorari on April 10, 1975, invoking the jurisdiction of this Court under 28 U.S.C. § 1254(1). The petition was granted on June 23, 1975.

STATUTES INVOLVED

1. Section 1 of the Robinson-Patman Act, 49 Stat. 1526, 15 U.S.C. § 13(a):

> "(a) It shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality, where either or any of the purchases involved in such discrimination are in commerce, where such commodities are sold for use, consumption, or resale within the United States or any Territory thereof or the District of Columbia or any insular possession or other place under the jurisdiction of the United States, and where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them. . . ."

2. The Nonprofit Institutions Act, 52 Stat. 446, 15 U.S.C. § 13c:

> "Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."

QUESTION PRESENTED FOR REVIEW

The Nonprofit Institutions Act of 1938, 15 U.S.C. § 13c, exempts from the Robinson-Patman Act purchases of supplies by nonprofit hospitals "for their own use." The Court of Appeals held, as a matter of law, that the exemption extends only to purchases of pharmaceutical products which are dispensed to hospital inpatients and to emergency room patients, and that purchases of drugs by hospitals for all other purposes are outside the scope of the exemption.

The question presented for review is whether drugs are purchased by nonprofit hospitals "for their own use" only if they are thereafter dispensed to hospital inpatients and to emergency room patients, and not if they are dispensed to patients treated as outpatients, to inpatients as take-home drugs when they leave the hospital, or to staff and employees of the hospital.

STATEMENT OF THE CASE

1. Proceedings in the Lower Courts.

Petitioners are twelve manufacturers of pharma-

ceutical products. Respondent filed this action for treble damages and injunctive relief as the assignee of the claims of some sixty commercial pharmacies doing business in metropolitan Portland, Oregon, charging petitioners with violations of the antitrust laws. The jurisdiction of the district court was invoked under 15 U.S.C. §§ 15 and 26 (R. 1-19).

Respondent's amended complaint stated five claims, only the second of which is before this Court (R. 52-69).[1] In its second claim, respondent alleged that in selling drugs petitioners discriminate between nonprofit hospitals and commercial pharmacies, including respondent's assignors (R. 61). As one affirmative defense, petitioners in their respective answers pleaded that their sales of drugs to nonprofit hospitals were exempt from the Robinson-Patman Act under the Nonprofit Institutions Act of 1938, 15 U.S.C. § 13c (R. 182-263).

The parties engaged in extensive discovery of the nonprofit status and drug dispensing practices of Portland area institutions that operate as nonprofit hospitals. Petitioners then filed a motion for summary judgment on the second claim under Rule 56 F.R. Civ. P. (R. 384-385).

On May 25, 1973 the district court granted the motion, concluding that there was no genuine issue as

[1] Charges of discrimination in sales to city, county and state governments and to the federal government were dismissed for failure to state a claim (R. 868-869). A charge of discrimination in sales to proprietary hospitals and commercial entities is pending, and discovery is proceeding. A fifth claim, charging that these alleged discriminations are the product of a conspiracy, also remains pending.

to any material fact with respect either to the nonprofit status of the hospitals or to their use of drugs. The court held that all of the hospitals were nonprofit institutions and that their drug purchases were exempt from the Robinson-Patman Act as a matter of law under the Nonprofit Institutions Act of 1938 (Tr. 5/25/73 at pp. 88 to 99).

In its oral opinion, the district court first considered the dispensing of drugs to inpatients, noting that "the vast majority of the drugs" are purchased for that purpose and that respondent conceded that such purchases are for the hospitals' "own use." It held that such purchases are clearly within the exemption of Section 13c (Tr. 92-93).

With respect to the hospitals' other uses of drugs, the district court held that drugs dispensed to outpatients are also purchased for the hospitals' "own use," and that this conclusion is not affected by the fact that many hospitals are expanding their outpatient services to the community.

> "I do not believe that it was the Congressional purpose to render inapplicable the statute merely because there was a change in the distribution of health care wherein the degree of out-patient treatment increased over the years since the 30's when this statute was passed" (Tr. 93).

The district court also held that take-home drugs "are indeed for the use of the hospital and thus qualify for the exemption", and that dispensing drugs to employees and staff physicians for personal and

family use also "may fairly be said to be for the use of the hospital" (Tr. 93-94).

On these grounds, the court entered summary judgment for petitioners on respondent's second claim (R. 868-869).

The district court certified its judgment order under 28 U.S.C. § 1292(b), and respondent appealed to the Court of Appeals for the Ninth Circuit. On December 26, 1974 the Court of Appeals rendered its opinion vacating the judgment (Petition A1 to A9).[2]

It affirmed the district court's decision that the thirteen hospitals (referred to hereafter as "the hospitals") which render services to the public generally are nonprofit institutions and qualify for the exemption under Section 13c (Pet. A3 to A4).[3] It also agreed with the district court that "by far the greater part of hospital distribution" is for inpatient and emergency treatment and is within the scope of the Section 13c exemption (Pet. A6).

However, the Court of Appeals disagreed with the district court over the proper interpretation of Section 13c as applied to other drug dispensing by the

[2] The appendix has been deferred by stipulation, Rule 34 (4), and references to the opinion of the Court of Appeals will be to appropriate pages of the petition for certiorari, where it is reproduced.

[3] The Court of Appeals found that there were disputed issues of fact relating to Bess Kaiser Hospital, which is affiliated with a health maintenance organization that principally serves its own members, and remanded those issues to the district court for further proceedings (Pet. A4 to A5). No party has sought review of the court's disposition of that aspect of the case.

hospitals. It held, as a matter of law, that a hospital's "own use" of drugs under the statute includes only drugs administered to inpatients and to patients in the emergency room. Thus, in the court's view, drugs dispensed to registered hospital patients who are treated as outpatients, to inpatients as take-home drugs at the time of their discharge, and to hospital employees and staff physicians for personal and family consumption are not purchased for the hospital's "own use" and are not exempt from the Robinson-Patman Act (Pet. A6 to A7).[4]

The Court of Appeals summarized its views as follows:

> "We may concede that in these respects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' 'own use.' Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of in-patients or emergency patients. The purpose for which these supplies are purchased — the use to which they are to be put — is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer." (Pet. A7).

[4] Three other kinds of hospital drug dispensing referred to by the Court of Appeals (Pet. A5 to A6) do not occur in significant amounts: To physicians for dispensing in the course of their private practices, to discharged patients as refills of take-home prescriptions, and to walk-in customers.

The court remanded the case for further proceedings (Pet. A9). Petitioners filed a timely petition for rehearing and suggestion for rehearing in banc, which was denied on March 11, 1975 (Pet. A18 to A19). On April 10, 1975 petitioners filed a petition for certiorari, which was granted on June 23, 1975.

2. Statement of the Facts.

A.

The facts with respect to the hospitals' distribution of drugs,[5] viewing the evidence favorably to respondent,[6] are summarized in the opinion of the Court of Appeals. The record on which the opinion is based shows the following:

Each of the hospitals has a pharmacy through which it dispenses drugs, primarily to inpatients. The pharmacy is an integral department of the hospital, and its operation produces revenues in excess of costs which belong to the hospital and are used to support

[5] The hospitals are:
Dwyer Memorial Hospital & Medical Center
Emanuel Hospital
Good Samaritan Hospital & Medical Center
Gresham Community Hospital
Holladay Park Hospital
Physicians and Surgeons Hospital
Portland Adventist Hospital
Portland Osteopathic Hospital
Providence Hospital
St. Vincent Hospital & Medical Center
Tuality Community Hospital
Willamette Falls Community Hospital
Willamette Methodist Convalescent Center (Pet. A2, n. 3).

[6] See *Arnett* v. *Kennedy* (1974) 416 U.S. 134, 139-140.

departments and activities which do not generate sufficient revenue to maintain themselves (see Table 1 at p. 31 below).[7]

Persons receiving hospital services are broadly classified as inpatients and outpatients, which are described in the Department of Health, Education and Welfare Hospital Insurance Manual and in publications of American Hospital Association.[8] An inpatient, according to HEW, is anyone who is admitted for overnight bed occupancy to receive hospital services. An outpatient is anyone who is registered on the hospital records as an outpatient and "receives services (rather than supplies alone) from hospital personnel." A "day patient," i.e., an individual who receives hospital services during the day but is not expected to remain at night, is an "outpatient." American Hospital Association defines an inpatient as one "who is given lodging while receiving physician, dentist or allied services in the hospital"; an outpatient is a pa-

[7] In Exhibit 1 to this brief are tables of references to the deposition testimony of more than 30 hospital witnesses which describe the pharmacy policies and operations of the hospitals.

[8] Hospital witnesses agreed with these definitions: Emmanuel (Hanson Dep. 7-10, H Ex. 2); Good Samaritan (Kaeser Dep. 7, Exs. 3, 4); Providence (Wong Dep. 26-27, Exs. 9, 10); St. Vincent (McConnell Dep. 20, Mc Ex. 2; Camosso Dep. 36); Adventist (Shupe Dep. 9-10, Exs. 4, 5, 6); Portland Osteopathic (Matlick Dep. 19-20); Physicians and Surgeons (Bleckinger Dep. 10-11, Ex. 7); Tuality Community (Hastings Dep. 9); Willamette Methodist (Slick Dep. 12); Holladay Park (Zeasas Dep. 26-27, Exs. 14, 15); Dwyer Memorial (Lindley Dep. 5; Haas Dep. 13-14); Willamette Falls (Hollowell Dep. 8-9).

tient "who is not lodged in a hospital" while receiving such services.[9]

In the most recent periods for which hospitals could supply data, inpatient drug sales accounted for about 90 percent of all pharmacy revenues.[10]

B.

Three kinds of drug dispensing are principally in issue:

1. Take-home drugs.

These are drugs that are dispensed by the hospital on the instructions of treating doctors to be taken home by patients when they are discharged. Amounts are determined in each case by the treating doctor and are normally limited to a short-term supply (see Table 2 at p. 32 below).

[9] The record shows one variation: At Emanuel Hospital, persons receiving "day surgery" are regarded as inpatients, while HEW regards this as an outpatient service (Hanson Dep. 10).

[10] At the request of the district court (Tr. 1/8/73 at pp. 11, 16, 20), the parties prepared charts, which are in the record, summarizing hospital drug distribution as shown by the depositions of hospital witnesses and by hospital records (Supp. Rec. 11/14/73 at p. 2). The charts were closely similar, and petitioners, for purposes of their motion for summary judgment, accepted respondent's chart as an accurate summary of the record with respect to the hospitals (Tr. 5/25/73 at pp. 16 to 17).

2. Drugs dispensed to registered outpatients.

Six of the hospitals have outpatient clinics[11] where persons registered as hospital patients are treated on an ambulatory basis. Prescriptions written for those patients are routinely filled at the hospital pharmacies. Many outpatient clinics primarily serve the poor and are operated at a loss; in addition, they are an important part of the hospital's educational program, providing a teaching resource for resident and intern doctors and for nurses (see Table 3 at p. 33 below). New hospital outpatient services such as maternal and infant care and family planning are also being developed (Hanson Dep. 21-25). At Willamette Methodist, persons living at a nearby retirement home are treated as outpatients at its convalescent center (Slick Dep. 11-12).

3. Drugs dispensed to employees, students and staff doctors.

All of the hospitals permit their employees (nurses, technicians, etc.), students, and staff physicians to purchase drugs at the hospital pharmacy for their personal use and for the use of members of their immediate families,[12] as a fringe benefit of their hos-

[11] Emanuel (Hanson Dep. 21-26); St. Vincent (Camosso Dep. 14, 39-40); Good Samaritan (Kaeser Dep. 33, 45, 53); Providence (Wong Dep. 8 and Johnston Dep. 39-40); Holladay Park (Zeasas Dep. 34-35); and Willamette Methodist (Slick Dep. 23-24).

[12] Some of the hospitals treat volunteer workers as employees for this purpose, e.g., Emanuel (Fawkes Dep. II, 31-32); Good Samaritan (Kaeser Dep. 35, 43, 46); Providence (Wong Dep. 21, 31-32); Holladay Park (Zeasas Dep. 20-21).

pital employment (Camosso Dep. 8, 12, 13). This "pharmacy privilege" is described in literature handed to newly-hired employees and is provided for in the collective bargaining agreements of some of the hospitals (see Table 4 at p. 34 below).

C.

The hospitals do not engage in commercial redistribution of drugs that they purchase. Occasional sales are made to walk-in customers, that is, persons having no connection with the hospital, but their volume amounts to less than one-half of one percent of drug sales. The hospitals do not seek or advertise for walk-in business, and sales of this type, when they do occur, often take place during hours when commercial pharmacies are closed and the purchaser has an immediate need for the medication (see Table 5 at p. 35 below).[13]

None of the hospitals supplies drugs to other markets. None purchases drugs for, or distributes them to, other hospitals or pharmacies, except on occasions when a drug is needed because of an emergency (see Table 6 at p. 36 below).

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[13] Dwyer Memorial Hospital will handle walk-in business "on a limited basis," usually for elderly persons residing in the immediate area, or on referrals from community pharmacies for specialty items (Haas Dep. 8-9, 19). Willamette Methodist Hospital will serve retired persons living at Willamette View Manor, which is nearby, but will not serve other walk-ins (Slick Dep. 11-13, 25; Renfrow Dep. 13-14, 23). Both of these hospitals are small and are located in outlying suburban neighborhoods.

SUMMARY OF ARGUMENT

The Nonprofit Institutions Act of 1938 was enacted so that hospitals and other nonprofit institutions that serve important public interests could lawfully purchase their supplies as inexpensively as possible. As applied to hospitals, the Act is not limited to purchases of drugs that are dispensed to bed patients and to emergency patients. Hospital use of drugs includes other critically important services to patients that the court recognized are "proper" hospital functions but declined to include within the exemption of the Act. The Court of Appeals erred in holding that drugs are not purchased for the hospital's "own use" if they are thereafter dispensed as take-home drugs, or to hospital outpatients, or as a "pharmacy privilege" to employees and staff doctors.

1. The legislative history of Section 13c shows that Congress intended to enact a broad exemption to the Robinson-Patman Act based on the public and nonprofit character of the beneficiary institutions. The exemption should not be limited to purchases for "noncompetitive uses" that cannot be supplied by regular commercial channels and would not violate the Robinson-Patman Act in any case.

2. The Section 13c exemption extends to all purchases of supplies for use in carrying on medical care programs of nonprofit hospitals. In *Logan Lanes, Inc.* v. *Brunswick Corporation*, (9th Cir. 1967) 378 F.2d 212, cert. den. (1967) 389 U.S. 898 the court correctly held that the exemption applies to all purchases of

supplies to meet the institution's needs, however they are disposed of and whether or not the public has access to them or the institution earns net revenues from their use.

3. The Section 13c exemption should be construed to follow modifications of hospital programs that are responsive to public needs and which expand outpatient and other services to persons who are not bedridden. Drugs are as important a component of outpatient care as of inpatient care, and dispensing drugs to outpatients from supplies maintained by the hospital and available for that purpose is part of its responsibility for their medical care.

4. Filling take-home prescriptions is a critical part of the hospital's responsibility to its bed patients, many of whom are physically unable to secure drugs from commercial pharmacies when they are discharged.

5. Filling prescriptions for employees and staff doctors is an integral and important part of the hospital's working relationship with the people whose services make its successful operation possible.

6. The decision of the Court of Appeals will have serious adverse consequences for hospitals and their patients, including the prospect of higher costs for a significant part of hospital drug purchases, and may cause them to limit their services to the public. Segregating drug supplies or use would be a clumsy and impractical accommodation to the Court of Appeals' opinion and would increase the cost of the pharmacy operation to hospital users.

Hospital suppliers also face serious problems under the decision of the Court of Appeals. If a supplier wishes to extend discounts under Section 13c, it must police the hospitals' subsequent use of each item of drugs that they purchase and sustain the risk of retroactive liability for any failure to do so. Placing restrictions on the hospitals' use of the drugs would also expose it to the risk of liability for violating the Sherman Act. *United States* v. *Arnold, Schwinn & Co.*, (1967) 388 U.S. 365.

ARGUMENT

Introduction

The Nonprofit Institutions Act provides:

> "Nothing in sections 13 to 13b and 21a of this title shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit." 15 U.S.C. § 13c.

The question before the Court is defined by the statute — whether nonprofit hospitals purchase for their "own use" drugs which are dispensed in admittedly legitimate hospital functions other than providing bed care and emergency care. These additional hospital functions, which the Court of Appeals excluded from the statutory exemption as a matter of law,

include dispensing drugs to inpatients at the time of their discharge, to registered hospital outpatients, and to employees and staff doctors for personal and family use.

Thus, the dispute is not between the pharmacy profession and drug manufacturers. Rather, it is between commercial pharmacists on the one hand and nonprofit hospitals (and their pharmacists) on the other. It arises because the dispensing of drugs is a normal component of hospital treatment and service,[14] which are diverse and extend beyond the hospital ward. The hospital's compelling interest in maintaining supplies of drugs that are available to those whom it serves extends to all of them, including the bed patient who is being released and the ambulatory outpatient. Its functions and its responsibilities are not limited to the bedridden. The Court of Appeals applied a concept of the nature and functions of hospitals that is inconsistent with the facts of hospital operations and is contrary to the public interest.

1. The Nonprofit Institutions Act of 1938 was enacted to permit hospitals and other nonprofit institutions to obtain their needed supplies as inexpensively as possible. The decision of the Court of Appeals is inconsistent with that legislative purpose.

The legislative history of the Nonprofit Institutions Act of 1938 is inconsistent with the view of the Court of Appeals that the exemption it provides

[14] See *Hospital Building Co.* v. *Trustees of Rex Hospital*, (4th Cir. 1975) 511 F.2d 678, 683, pet. cert. pdg.

from the Robinson-Patman Act is limited by narrow concepts of institutional "use," so as to apply in this case only to drugs dispensed to bed patients and in the emergency room. On the contrary, the exemption statute was written to assist a wide range of nonprofit institutions to operate at the lowest possible cost in the public interest, and should be interpreted to achieve that legislative purpose.

The 1938 reports of the Judiciary Committee of the House and Senate recommending passage of HR 8148[15] concluded that it was not in the public interest to apply the Robinson-Patman Act to nonprofit institutions in whose operation the public has a substantial stake. It was the character of such institutions, not particular features of their programs, that made it inappropriate to apply the price discrimination act to their purchases.

Thus, in House Report 2161, 75th Cong., 3d Sess., April 19, 1938 the House Judiciary Committee recommended adoption of the bill to make certain that price reductions "to eleemosynary institutions, because of the character of the institution, do not fall under the ban of the act." Similarly, the report of the Senate Judiciary Committee stated that the legislative purpose of the Robinson-Patman Act in prohibiting price discrimination between purchasers "does not seem to apply as to eleemosynary institutions as they are not operated for profit. The act does forbid such favors

[15] The texts of the Committee reports are found at pp. 37-41 below.

as might now be granted by sellers to such institutions." Senate Report 1769, 75th Cong., 3d Sess., April 20, 1938.

The supporting letter of the President of the Hospital Bureau of Standards and Supplies, attached to both reports, emphasized the consequences of increasing the cost of operations of institutions that serve the public by caring for the "needy sick."[16] The record in this case shows that a major purpose of maintaining outpatient clinics for ambulatory patients at hospitals is to care for the needy sick; yet the Court of Appeals held, as a matter of law, that dispensing drugs to such registered outpatients in the course of their hospital care is not within the scope of the exemption. In fact, medical services to outpatients are as much the proper business of a modern hospital as services to inpatients, and the public interest in an economical hospital operation extends to both.

The Senate report also shows that the exemption was intended to reach and protect purchases of supplies which would otherwise violate the Robinson-Patman Act, i.e., it was the purpose of the 1938 statute to authorize price discriminations between customers, who were the primary beneficiaries of the 1936

[16] However, Congress refused to limit the exemption to institutions which operate at a loss or are subsidized by the public. As originally drafted, HR 8148 included only ". . . institutions not operated for profit *and supported in whole or in part by public subscriptions.*" The italicized language was deleted by the House Judiciary Committee. 83 Cong. Rec. 6065 (1938).

amendments to the Clayton Act,[17] when the favored customer was a qualified nonprofit institution. However, purchases of drugs held to be exempt by the Court of Appeals would not violate the Robinson-Patman Act in any case, because the court limited the exemption to purchases for uses which retailers cannot supply and which therefore can have no competitive impact on retailers.[18]

The legislative purpose to exempt the hospitals' purchases of supplies from the Robinson-Patman Act would be frustrated by limiting the statute to narrowly-defined institutional uses that do not reflect the range of their services to the public and cannot be supplied by other purchasers, such as respondent's assignors.

2. The Nonprofit Institutions Act of 1938 applies to all purchases of drug supplies by hospitals for dispensing in the course of providing their services to the community.

The Nonprofit Institutions Act of 1938, in general terms, exempts from the Robinson-Patman Act all purchases of supplies for the use of the purchasing institution. It should be construed to re-

[17] See generally Rowe, Price Discrimination Under the Robinson-Patman Act, (1962) pp. 3-23; Patman, Complete Guide to the Robinson-Patman Act, (1963 ed.) pp. 7-10.

[18] See *Ag-Chem Equipment Co., Inc.* v. *Hahn, Inc.*, (8th Cir. 1973) 480 F.2d 482, 490-491; *Sano Petroleum Corp.* v. *American Oil Co.*, (E.D. N.Y. 1960) 187 F. Supp. 345, 357; *Secatore's Inc.* v. *Esso Standard Oil*, (D. Mass. 1959) 171 F. Supp. 665; Rowe, Price Discrimination Under the Robinson-Patman Act, supra, (1962) p. 176; 1 Callman, The Law of Unfair Competition 969 (3d ed. 1967) § 28.1(b)(7).

flect all of the integrated operations of hospitals which purchase their supplies under its protection, not in narrow terms that will inhibit their programs of medical care or modifications of existing services in ways beneficial to the public.

This view is consistent with the analysis of the Act which was the basis of the same Court of Appeals' prior decision in *Logan Lanes, Inc.* v. *Brunswick Corporation*, supra, (9th Cir. 1967) 378 F.2d 212, cert. den. (1967) 389 U.S. 898, the only previous case that has closely considered Section 13c.[19] In *Logan Lanes*, the proprietor of a commercial bowling establishment sought to recover treble damages from a manufacturer of bowling alleys and equipment, charging that the defendant had sold its products to the state of Utah at discriminatory prices for installation and use in the student union of one of its universities, and that the facility was used by the public in competition with plaintiff's business.

The Court of Appeals affirmed a summary judgment in favor of defendant. It held, first, that it did not matter if public use of the student union alleys was profitable to the university, because all net rev-

[19] The Court of Appeals cited *Students Book Company* v. *Washington Law Book Co.*, (D.C. Cir. 1955) 232 F.2d 49, 50-51, n. 5, cert. den. (1956) 350 U.S. 988, in which there is a footnote reference to the Act in an opinion announcing, but dissenting from the panel's decision (Pet. A7 to A8). The footnote states that the book purchases in question were not made by the universities at all, but by self-sustaining campus bookstores for resale; consequently, they were not purchases by the universities for their "own use." See also Anno: 3 A.L.R. Fed. 996 (1970).

enues were devoted to university purposes. 378 F.2d at 216. See also *Community Blood Bank of Kansas City Area, Inc.* v. *FTC*, (8th Cir. 1969) 405 F.2d 1011, 1019-1020. Second, the court held that the exemption applies to anything purchased for the primary purpose of fulfilling the needs of the institution, "whether it is consumed or otherwise disposed of", and that the exact amount of public use of such purchases, even if substantial, is not material. 378 F.2d at 216-217.[20]

Thus, the *Logan Lanes* court did not pass judgment on the university's decision to provide bowling alleys for its students and faculty or consider if such facilities are relevant to a program of higher education. Instead, it recognized the congressional purpose to allow these institutions "to operate as inexpensively as possible," which was incompatible with a narrow view of the statute. 378 F.2d at 216.

The court's analysis of Section 13c in *Logan Lanes* is in sharp contrast with the decision of the same court in this case. The transactions in which drugs are dispensed by hospital pharmacies are the same in all cases — all hospital drugs are "sold," whether to

[20] The Court of Appeals thought that *Logan Lanes* was inapplicable to this case, because it concerned purchases of capital equipment as well as of supplies, and that capital items cannot be segregated (Pet. A8 to A9). This distinction is not supportable. The problem, if there is one, lies in permitting public access to that which has been purchased at favorable prices. In practical terms, it is as simple to require the identification of customers of an entertainment facility as customers of a pharmacy; indeed, in *Logan Lanes* this is what plaintiff contended the university should have done.

bed patients or to outpatients or discharged patients, or to staff for personal and family use. The distinctions suggested by the Court of Appeals between "dispensing," "providing," and "selling" drugs to various categories of customers (Pet. A5 to A6) are without substance and are of no aid in interpreting the statute.

The proposition that drugs are "consumed" by the hospital if the patient is in bed, but are "consumed" by the patient if he receives treatment at the hospital and takes the drugs home, is equally insubstantial (Pet. A7). Drugs are "consumed" by people, whether in or out of bed, not by institutions, and the attempt of the Court of Appeals to equate "consumption" and "use" leads nowhere. Neither of these verbal propositions is a sustainable analysis of the Act.

3. The Nonprofit Institutions Act of 1938 should be construed to include modifications of hospital programs that provide outpatient and other medical services in response to public needs.

One hundred years ago, the principal function of most hospitals was to care for the poor. Today, however, major advances in medical science, technology and equipment have imposed on hospitals responsibilities to the community at large, rich as well as poor. To meet those responsibilities, these institutions have become larger and their services more diverse.[21]

[21] See *Eastern Kentucky Welfare Rights Org.* v. *Simon*, (D.C. Cir. 1974) 506 F.2d 1278, cert. granted May 19, 1975, in which the court noted that hospitals have ceased to be caretakers of the sick poor, and have become "the primary community health facility for both rich and poor." This process has occurred in the face of soaring costs, as "constant modernization of equipment and facilities is necessitated by the advances in medical science and technology." 506 F.2d at 1288.

This has not been a sudden development, at least as applied to hospital functions that are now in controversy. In 1938, as today, hospitals dispensed drugs to patients at the time of their discharge and provided outpatient medical services.[22] The hospital drug uses involved in this case are not new.

It is clear, however, that changes in the delivery of hospital services have occurred since the Second World War and will continue to occur. The modern nonprofit hospital is no longer a facility that serves only the bedridden, just as it formerly ceased to be one dedicated only to serving the poor; under modern conditions, hospitals are becoming medical centers

[22] The first outpatient clinic in this country was established to serve the poor by the Pennsylvania Hospital of Philadelphia, the nation's oldest hospital, in 1752. By 1916 there were 495 outpatient departments of hospitals engaged in treating general diseases, and their development as teaching facilities and in treatment of the poor has been consistent and substantial, both before and since the Second World War. See generally Sussman, Caplan, Haug and Stern, The Walking Patient, Western Reserve University, 1967, at pp. 2-7; Better Hospital Care for the Ambulant Patient, Hospital Association of Pennsylvania, 1946, at p. 2; Davis and Warner, Dispensaries, MacMillan, 1918, at p. 36; Merrill, "Hospital Pharmacy and Out-Patient Department," Hospitals, June 1941, at p. 33. Dispensing drugs was an established service of outpatient clinics in 1918. Davis and Warner, *op. cit.* at pp. 74, 92-93, 187-189.

for the communities which they serve.[23] Costly equipment and technologies available only in hospitals are widely used in expanded services for diagnosis and care of the public, and it has become necessary to deliver hospital services as efficiently and as cheaply as possible.

As a result, there have been changes in the various services that are conventional parts of a hospital's program. A major one is that much diagnosis and therapy, including surgery, which formerly required bed care, is now widely performed on an outpatient basis which is beneficial to the patient, extends the use of available capital, and reduces costs. There is increasing emphasis on ambulatory services for outpatients which are provided by the hospital at its principal institution and at detached facilities.[24]

These modifications of traditional hospital practices are inevitably reflected, not only in purchases of equipment and materials to build facilities for outpatient services, but in purchases of supplies, including drugs that are dispensed to outpatients in the course of their treatment.[25]

[23] This evolution in the functions and services of hospitals is described in a paper presented in November 1970 at the dedication conference of the Purdue University School of Pharmacy and Pharmacal Science and reprinted in 28 American Journal of Hospital Pharmacy 240 (1971) and in HEW Publication DHEW Pub. No. (HMS) 73-3001. The authors are Donald C. Brodie, of the University of California, and Mrs. Joe B. Graber, who were, respectively, the Director and the Special Assistant to the Director of the drug-related studies program of HEW. Portions of the study are reproduced below at pp. 42-43. See also John H. Knowles, The Hospital, Scientific American, September 1973, pp. 128, 136.

[24] See generally, Sussman, Caplan, Haug and Stern, The Walking Patient, supra, at pp. 4-7.

The application of Section 13c to drugs dispensed to these patients cannot depend on the capacity or willingness of commercial pharmacies to supply some part of them. This use is an integral part of the hospital care which the ambulatory patient receives from the institution; the controlling circumstance is that the drugs are dispensed to the patient by the hospital in connection with its services, whether he is sitting, standing or lying down, and wherever he may be when he consumes them.

Under the Act, hospital "use" extends to all dispensing of drugs that occurs in connection with the hospital's services, including its care of those who are not bedridden. The increased dispensing of drugs to ambulatory patients that has accompanied these trends in hospital services does not exceed the terms or intent of a statute which was intended to permit nonprofit hospitals to operate inexpensively in the public interest. The reference in the Act to a qualified institution's "own use" of supplies purchased at reduced prices is comprehensive; it is not a definition of "use," but merely describes the buyer's purpose in unrestricted and general terms. The statute must be construed to accommodate modifications of hospital programs that are the result of changing conditions.

[25] See Francke, Latiolais, Francke and Ho, Mirror to Hospital Pharmacy, American Society of Hospital Pharmacists, 1964, at pp. 67-68, 117-120.

4. Purchases of drugs dispensed in filling take-home prescriptions are within the Section 13c exemption.

The universal hospital practice of dispensing drugs to bed patients for use after leaving the institution is a necessary service of the hospital that provides continuity during the transition from hospital care to home care. Newly discharged hospital patients cannot be expected to patronize the corner drugstore, and the hospital can scarcely abandon them in the expectation that they will do so. In fact, many are not yet well enough and do not have the support of a family or others who might assist them to get drugs. The narrow construction given to Section 13c by the Court of Appeals, which considered only the place where the patient consumes the drug, ignores the practical and pressing needs of those who are discharged from hospital bed care.

For any purpose relevant to the statute, dispensing drugs to a bed patient who is going home is indistinguishable from dispensing the same drugs to the patient before he is discharged. Both are essential to the responsible rendering of hospital services, and purchases of drugs for such purposes are within the scope of the Act.

5. Purchases of drugs dispensed to employees and to medical staff under the pharmacy privilege are within the Section 13c exemption.

The pharmacy privilege that all of the hospitals extend to their employees, students and staff physi-

cians, often at a discount, is equally important in achieving the institution's purposes.

A hospital is an association of facilities and people who pursue a common undertaking, and the privilege of purchasing drugs at the hospital pharmacy is part of the working relationship between the institution and its employees and medical staff, a relationship which may also include a lunch room supplied with food purchased at reduced prices and other benefits that "compete" with nearby businesses. The privilege is a conventional "fringe benefit" that is not significantly different from a wide range of other in-house benefits that are characteristically afforded by profit and nonprofit institutions alike to promote job affiliation and performance.[26]

The "pharmacy privilege" is an established and important characteristic of nonprofit hospitals, and it constitutes the institutions' "own use" of drugs within the meaning of Section 13c.

6. The decision of the Court of Appeals establishes an unworkable standard for hospitals and their suppliers.

The decision of the Court of Appeals is an unfortunate distortion of Section 13c which adversely affects all nonprofit institutions which charge their constituency for supplies that are consumed in the course of educational, religious, medical or other programs. Present consideration, however, is limited to the

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[26] E.g., faculty and staff use of university bowling alleys that was considered in *Logan Lanes*, supra, 378 F.2d at 216.

parties to a hospital pharmacy transaction — the hospital, the drug purchaser and the supplier.

The Court of Appeals' decision impairs the operation of the statute, so as to threaten hospitals with increased costs and the public with reduced levels of service. There are at least two undesirable consequences of the decision: First, by sharply limiting the use of drugs purchased at favorable prices under Section 13c, the decision may increase direct institutional costs by requiring a significant portion of all hospital drugs to be purchased at regular trade prices. Second, the decision requires a segregation of drugs or accounting of their use that can be achieved only through the institution of clumsy and expensive dual supply or tracing systems to regulate and account for the use of drugs.[27]

The hospitals could, of course, give up lawful discounts on their drug purchases for inpatients and emergency patients, or they could cease to provide drugs for other "proper," but excluded, hospital functions — with no assurance that retail pharmacies would provide alternative supplies when and as they are needed. These choices can hardly be regarded as in the public interest.

Equally serious are the problems that the decision

[27] The Court of Appeals believed that drugs for "non-hospital" use "can readily be segregated" (Pet. A9), a view that is almost certainly incorrect. Hospitals can scarcely be expected to operate two pharmacies, one for inpatients and emergency room patients to whom the bulk of their drugs are dispensed, and another for all other drug dispensing. This would require separate purchasing, separate inventories, separate accounting, separate dispensing and separate pricing.

presents to those who supply drugs to nonprofit hospitals. Some suppliers have sought to prevent the commercial redistribution of drugs supplied to nonprofit hospitals at reduced prices by placing appropriate labels on the containers or by agreements restricting subsequent distribution (e.g., R. 871-873; Chartier Dep. Ex. 13-15). Others have not done so, which is understandable in light of the problems involved in controlling the disposition of merchandise in the hands of a purchaser. *United States* v. *Arnold, Schwinn & Co.*, supra, (1967) 388 U.S. 365, 379.

These devices, however, do not reach the case of a drug that disappears into a hospital inventory from which it may be dispensed in a "proper" hospital use, but one not recognized by the Court of Appeals. The result can be retroactive exposure to claims such as this, based on what the supplier's customer ultimately does with a small proportion of products that it purchases in substantial quantities.

The supplier's alternatives are also undesirable: It can, of course, abandon discounts to nonprofit hospitals, which is inconsistent with the statutory purpose to promote the inexpensive operation of these institutions; or it can try to police the hospital's use of the drugs, which presents it with the risk of liability under the Sherman Act.

The decision of the Court of Appeals is an unworkable limitation upon Section 13c that defeats the statutory purpose.

CONCLUSION

The judgment of the Court of Appeals should be reversed, and the district court's summary judgment construing Section 13c should be reinstated.

Respectfully submitted,

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August 7, 1975

EXHIBIT 1

TABLE 1. Use of net revenues from distribution of drugs for hospital purposes

Emanuel	Gustafson 4, 15-16; Steed 11.
St. Vincent	Camosso 18, 19.
Good Samaritan	Smith 10.
Providence	Johnston 5, 29, 38-39, 42-43; Wong 4-5.
Adventist	Ammon 28.
Osteopathic	Bremner 24-25; Matlick 4, 24-25, 26.
Gresham Comm.	Mack 5, 8, 13.
Phys. & Surgeons	Desrosiers 9-10.
Tuality	Hastings 5, 24-25.
Willam. Methodist	Slick 8-9, 22.
Holladay Park	Sperry 5, 14, 24; Zeasas 30.
Dwyer Memorial	Lindley 4, 15.
Willam. Falls	Hollowell 5, 10.

TABLE 2. Sales of take-home drugs and policy against refilling such prescriptions

Emanuel	Fawkes 20-21, 29, 37; Fawkes II 26-27, 41, 43; Gustafson 17-19, Ex. FX13.
St. Vincent	McConnell 23-26, 28-29; Camosso 7-8, 12-13.
Good Samaritan	Kaeser 8-10; Ex. KX7.
Providence	Johnston 17; Wong 25, 30-31.
Adventist	Ammon 23-24; Shupe 21, 27; Ex. SX2.[1]
Osteopathic	Bremner 11; Matlick 13-14; Ex. MX7, 9-13.
Gresham Comm.	Mack 6-7; Chartier 12-13; Ex. MX4, CK6.
Phys. & Surgeons	Desrosiers 6-7; Bleckinger 12; Ex. DX3.
Tuality	Eldien 11-12; Ex. HX7, 8, 15, 16.
Willam. Methodist	Renfrow 8-9, 11-12.[2]
Holladay Park	Sperry 7; Zeasas 15-16, 33.
Dwyer Memorial	Lindley 5-6; Haas 15-16.[3]
Willam. Falls	Hollowell 8; Ferrell 7, 14-16; Ex. HX11.

[1] Adventist will refill take-home prescriptions if the patient insists, but it discourages the practice. Adventist and Tuality prescription labels advise the patient to secure refills elsewhere.

[2] Willamette Methodist has no rule against refilling take-home prescriptions, but refills are rarely requested.

[3] Dwyer Memorial refills about one take-home prescription per day.

TABLE 3. Charitable and teaching functions of hospital outpatient clinics

Emanuel	Hanson 21-26.
St. Vincent	Camosso 14, 39-40.
Good Samaritan	Kaeser 33-34, 45.
Providence	Johnston 39-43; Wong 8, 32.
Willam. Methodist	Slick 23-24, 26-27.
Holladay Park	Sperry 20-21.[1]

[1] Holladay Park's outpatient clinics are primarily for providing post-discharge psychiatric treatment and occupational therapy.

TABLE 4. Sales to employees, students and staff physicians for personal and family use

Emanuel	Hanson 11-13, 25; Fawkes 5, 33; Gustafson 4-6; Steed 12; Ex. SX-4.
St. Vincent	McConnell 17-19, 22-23, 29-31; Camosso 28-31; Ex. CX10.
Good Samaritan	Kaeser 25-26, 31-32, 34, 38-40; Stocks 7, 11; Ex. KX15, ESX19.
Providence	Johnston 22-23; Wong 9-13, 22-23; Ex. JX19.
Adventist	Ammon 21-22;[1] Shupe 12-14, 28.
Osteopathic	Bremner 7; Matlick 10, 12, 19; Ex. MX5, 6.
Gresham Comm.	Mack 9, 11-12; Chartier 10-11; Ex. CX5.
Phys. & Surgeons	Bleckinger 6-8, 10-11; Desrosiers 7, 24; Ex. DX4.
Tuality	Hastings 10-11, 19-20; Eldien 5, 7; Ex. HX7, 10-12, EX13.
Willam. Methodist	Renfrow 10, 15-16; Slick 12, 18-19; Ex. SX5.
Holladay Park	Sperry 8; Zeasas 6, 17-19; Ex. SX3, 4.
Dwyer Memorial	Lindley 10-11; Haas 4-6, 20-21.
Willam. Falls	Hollowell 20-21; Ferrell 7-8, 9-10.

[1] Mr. Ammon testified that while there are no restrictions on purchases by employees and physicians, "it doesn't happen" that doctors fill their office needs at the Adventist hospital pharmacy.

TABLE 5. Lack of walk-in sales and policy against such sales

Emanuel	Hanson 12, 19; Fawkes 5-6, 10-12, 27, 29-30, 34; Fawkes II 30-31; Gustafson 7-8; Ex. FX13.
St. Vincent	McConnell 20-22, 46-47.
Good Samaritan	Kaeser 5-6, 10-11, 14-15, 39, 41-44; Ex. KX7.
Providence	Wong 21-22, 32-33.
Adventist	Shupe 24-25, cf. 31-32.
Osteopathic	Bremner 10-11, 25, 27; Matlick 10; Ex. BX14.
Gresham Comm.	Chartier 13, 15-16; Ex. CX6.
Phys. & Surgeons	Bleckinger 6-7; Desrosiers 16.
Tuality	Hastings 23.
Willam. Methodist	Renfrow 13-14.
Holladay Park	Sperry 10; Zeasas 6-7, 9-10, 19, 25-26, 32-33, 37.
Dwyer Memorial	Lindley 7-8; Haas 20; Ex. LX3.
Willam. Falls	Hollowell 19-20; Farrell 20.

TABLE 6. Policy prohibiting commercial redistribution of drugs

Emanuel	Hanson 13; Fawkes 15-17; Gustafson 5-6.
St. Vincent	McConnell 31; Camosso 14.
Good Samaritan	Kaeser 25, 50-51.
Providence	Johnston 18.
Adventist	Shupe 19-20.
Osteopathic	Bremner 20-22; Matlick 16-17.
Gresham Comm.	Chartier 16.
Phys. & Surgeons	Bleckinger 8-9; Desrosiers 13.
Tuality	Eldien 7.
Holladay Park	Zeasas 20.

EXHIBIT 2

NON-PROFIT INSTITUTIONS ACT REPORT
HOUSE OF REPRESENTATIVES

75TH CONGRESS
3rd Session

REPORT
No. 2161

EXEMPTION OF ELEEMOSYNARY INSTITUTIONS FROM THE ROBINSON-PATMAN ACT

April 19, 1938—Referred to the House Calendar and ordered to be printed

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MR. WALTER, from the Committee on the Judiciary, submitted the following

REPORT

[To accompany H.R. 8148]

The Committee on the Judiciary, to whom was referred the bill H.R. 8148, to amend Public Law No. 692, Seventy-fourth Congress, second session, after consideration, report the same favorably to the House with an amendment with the recommendation that as so amended the bill do pass.

The committee amendment is as follows: "Strike out all of line 9."

The reported bill provides that the Robinson-Patman Act shall not apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit.

The Robinson-Patman Act prohibits price discriminations between purchasers in interstate commerce, excepting differentials which make only due allowance for differences in the cost of manufacture, sale, or delivery resulting from the different methods or quantities in which such commodities are sold and delivered, where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition.

The committee does not feel that the wholesome purpose of the Robinson-Patman Act will be interfered wtih by the enactment of this bill to make certain that favors in price which are occasionally extended to eleemosynary institutions, because of the character of the institution, do not fall under the ban of the act.

In this connection there follows a self-explanatory communication from the president of the Hospital Bureau of Standards and Supplies, a nonprofit-making association of 200 voluntary hospitals located from Maine to Texas:

HOSPITAL BUREAU OF STANDARDS AND SUPPLIES,
New York, N. Y., December 18, 1937.

Hon H. W. SUMNERS,
United States House of Representatives
Washington, D. C.

MY DEAR CONGRESSMAN: The 2,700 voluntary nonprofit hospitals of the country spend over 150 mil-

lion dollars a year on foodstuffs and supplies for the care of the needy sick, who would otherwise be a burden on Federal, State, and municipal institutions.

Because of the charitable nature of their work many suppliers have hitherto allowed these institutions special prices on their purchases. This the Robinson-Patman Act now prohibits and as a consequence, hospital supply bills are increasing about 20 percent.

Most, if not all, of these institutions have for years operated at a deficit. If these deficits are to be increased by 30 million dollars a year, many hospitals may have to close their doors. The needy sick must be cared for and such a development would throw an almost impossible additional burden on the Federal, State, and municipal institutions.

We, therefore, respectfully request that you keep these facts in mind when the proposed amendment to the Robinson-Patman Act, exempting the eleemosynary institutions of the country, comes up for consideration of the Congress.

Sincerely yours,

JOHN H. HAYES, *President.*

75TH CONGRESS
3d Session

REPORT
No. 1769

SENATE

EXEMPTION OF ELEEMOSYNARY INSTITUTIONS FROM THE ROBINSON-PATMAN ACT

April 20 (calendar day, May 10), 1938
Ordered to be printed

MR. LOGAN, from the Committee on the Judiciary, submitted the following

REPORT

[To accompany H.R. 8148]

The Committee on the Judiciary, to whom was referred the bill (H.R. 8148) to amend Public Law No. 692, Seventy-fourth Congress, second session, after consideration of the same, report favorably thereon to the Senate with the recommendation that it do pass.

The bill provides that the Robinson-Patman Act shall not apply to purchases of supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit.

The purpose of the Robinson-Patman Act, to prohibit price discrimination between purchasers in interstate commerce where competition would thereby be lessened, does not seem to apply as to eleemosynary institutions as they are not operated for profit. The

act does forbid such favors as might now be granted by sellers to such institutions.

There follows a self-explanatory communication from the president of the Hospital Bureau of Standards and Supplies, a nonprofit association of hospitals, which letter was considered by the House.

• • •

EXHIBIT 3

From 28 American Journal of Hospital Pharmacy 240 (1971):

> Early in the 1960's the American Hospital Association approved a ". . . Statement on the Changing Hospital. . . ." The underlying concept in the Statement was that the hospital would become the repository for and custodian of a community's health resources — physical plant, technical manpower and equipment. Steps were taken in the past decade toward fulfilling this projection, in fact, some believe the hospital now is acquiring the qualities of the community health center.
>
> Numerous factors are contributing to this development. For example, the hospital is growing "centrally" because of increasing demands for its services, continual scientific specialization, and centralization of health resources. On the other hand, it is growing "peripherally" since it is being required to extend its services into the community because of the forces created by the physician shortage in selected areas and the need for lessening the high density of patients at the hospital. Thus, the community hospital is growing "inwardly" and "outwardly" simultaneously.
>
> As health centers, some community hospitals are providing a full spectrum of diagnostic and treatment services to the sick in addition to preventive and maintenance services to the apparent well. Community hospitals are assuming responsibility for selected social, environmental, rehabilitative and other health-related services. Some of

> this centralization of services has resulted from shifts taking place in the delivery of selected services from long-term to acute care hospitals. The sharing of services also has been a contributing factor.
>
> The emergence of the hospital as a community health center frequently represents a realignment of resources and management. Horizontal realignment is taking place through the establishment of satellite hospital systems, chains and mergers, while vertical realignment is seen where hospitals are providing for graded levels of care.
>
> The facilities for a system of comprehensive care may be clustered on a common campus, structured around the hospital. In other cases, services will be provided in an off-campus facility located at some other point in the community to facilitate access to primary care of some specialized service. Modern communication systems will permit continuous contact with the parent institution. Whatever arrangements develop in a given community, the hospital retains the central focus while its authority and that of its medical staff will extend to wherever in the community its services are needed.

Supreme Court, U. S.
FILED
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No. 74-1274

In the Supreme Court

of the United States

OCTOBER TERM, 1974

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

RESPONDENT'S BRIEF

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A Report to the President, Dept. H.E.W. (Feb. 1967) 12, 61

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Barker & McConnell, "How to Detect Medication Errors," 99 Modern Hospitals 94 (1962) 62

Bodenheimer, "Patterns of American Ambulatory Care," VII Inquiry 26 (Sept. 1970) 26

Brodie & Graber, "Institutional Pharmacy Practice in the 1970's, *28 American Journal of Hospital Pharmacy* 240 (1971) 26

Broom, Legal Maxims 39

California Legislature Assembly Interim Report 68, 69

Clarke, "Medications for Outpatients," *20 Hospitals* 60 (Oct. 1946) 58

Commerce Clearing House, State Tax Guide 42, 43

Drug Intelligence II, Nov. 1968, 305-319, "A Report of the Iowa Drug Distribution System" 62

Edwards, The Price Discrimination Law 286 34

Francke, Latiolais, Francke & Ho, *Mirror to Hospital Pharmacy* 118 (1964) 58

Goddard, *229 The Scientific American* 161 (1973) 5

H.E.W. Publication No. (S.S.A.) 73-10050, *Your Medicare Handbook* 61

H.E.W. Pub. (10-71), *Health Insurance Manual* 210 ..... 9, 10

Hearing on Conditions and Problems of the Nation's Nursing Homes, Subcommittee on Long Term Care, Special Commission on Aging, U. S. Senate, 89th Cong., 1st Sess., Pt. 22 (Feb. 15, 1965) 51

Hearing on Price Discrimination before the House Select Committee on Small Businesses, 84th Congress, 1st Session, Pt. 1 (1955) 631 65

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Johnson & Christianson, *A Report of the Kaiser Foundation Drug System* (January, 1971), Greenlick Depo. Exhibit No. 3 ..... 18, 25, 62

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Knowles, "The Hospital," *Scientific American* (Sept. 1973) 21, 50

Lincoln's First Inaugural Address (March 4, 1861) 39

Martin, "Control of Out-Patient Services and Charges," *Hospitals* (Sept. 1942) 52

Nicholson, *Practical Builder* (1823) 41

Pacific Northwest Bell, Portland Telephone Directory (1975) 56

Patman, *Complete Guide to the Robinson-Patman Act*, 23 ..... 34, 65

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Perkoff & Anderson, "Relationship between Demographic Characteristics, Patient's Chief Complaint, and Medical Care Destination in an Emergency Room," *VIII Medical Care* (July-Aug. 1970) 51

S.R. 1769, 75th Cong., 3d Session 34

Standard & Poor, *42 Standard N.Y.S.E. Stock Reports* 4

Stewart & Cluff, "A Review of Medication Errors & Compliance in Ambulant Patients," *13 Clinical Pharmacology & Therapeutics* (July-August 1972) 463 62

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In the Supreme Court
of the United States

OCTOBER TERM, 1974

No. 74-1274

ABBOTT LABORATORIES, an Illinois corporation, et al.,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENT'S BRIEF

ISSUE ON APPEAL

Should the explicit language of the Nonprofit Institutions Act (15 U.S.C. 13c), which contains a limited exemption from the Robinson-Patman Price Discrimination Act for:

> ". . . purchases of their supplies for their own use by . . . hospitals, and charitable institutions, not operated for profit."

be tortured to include those prescription and over-the-counter drugs acquired by hospitals at lower prices than those charged drug stores, but later resold by the hospital to:

> "3. . . . in-patients as take-home prescriptions."
> "5 . . . for home treatment to out-patients either at hospital pharmacies or at out-patient clinics."
> "6 . . . to hospitals' employees and students for the private use of purchasers."
> "7 . . . to hospitals' physicians for their personal or family' use . . ."

for their private use when they return to their own homes? Some in these categories (e.g., oral contraceptives users, purchasers of vitamins, etc.) are not ill.

(Respondent is the assignor of 60 Portland, Oregon area drug stores. These are primarily small stores in urban and suburban locations. They are called community, neighborhood, or retail pharmacies or sometimes corner drug stores. We will refer to them as drug stores to distinguish them from hospital pharmacies or drug rooms. More and more the operation of hospital pharmacies resembles those of drug stores.)

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[1] See infra pp. 3-4.

SHIFT IN POSITION BY PETITIONERS

Petitioners' present stance is a sharp departure from that asserted below, where they contended 100% of all purchases by hospitals were exempt and it was immaterial what the hospitals subsequently did with them.

Evidently petitioners now concede the Court of Appeals was correct when it held that drugs sold by the hospitals under the following circumstances are not within the 13c exemption, when

> "4. They were provided to persons who had been in-patients as renewals of prescriptions which had first been filled while those persons are in-patients."
> "7. They were sold to hospitals' physicians for their . . . dispensation in the course of their private practice."
> "8. They were sold to walk-in customers who were not hospital patients."

since none of these are mentioned by petitioners.

Not mentioned by petitioners are other categories of hospital drug resale, such as:

> (a) mail order service to those who write to the hospital;
> (b) drug stores and other hospitals for further resale; and
> (c) pensioners, clergy, and in-laws of hospital employees and staff members.

ADDENDA

There is a possibility petitioners may have shifted position once more.

Petitioners' petition for certiorari at p. 7 may be interpreted as challenging that part of the Court of Appeals' ruling which held that hospital drug resales to families of staff doctors and families of employees were not within the 13c exemption. However, such sales are not discussed in petitioners' principal brief.

PRELIMINARY COMMENT

Nonissues

Respondent has never questioned the right of a hospital to sell drugs to anyone.

Nor has respondent suggested manufacturers raise their hospital selling prices, or that discounts to hospitals be ended for drugs actually used for the hospitals' "own use".

Respondent asks only that if drugs are sold to hospitals for purposes of resale, and not for the hospitals' own use, that manufacturers charge a like price to drug stores. If hospitals wish to operate as drug stores then in fairness their acquisition prices should be equalized for those items where they compete.

Parity need not mean any change in petitioners' charges to hospitals. There is every reason to believe petitioners could equalize charges to drug stores with-

out strain. Drug manufacturers' profit margins are among the highest in American industry,[2] not to mention their swollen advertising budgets.[3] Studies by the Kefauver committee reveal that if drug manufacturers were truly competitive, consumer prices could be cut "in range of 80%".[4]

The House subcommittee report on Small Business Problems in the Drug Industry" (H. R. No. 1983, 90th Cong., 2nd Sess. 79 (1968)), concluded that the

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[2] 42 Standard N.Y.S.E. Stock Reports, Standard & Poor's, 16, 126, 370, 457, 784, 1268, 1354K, 1941, 2096K, 2420.

In 229 *The Scientific American* 161 (1973) by Dr. James Goddard former chief of the FDA, states: "The pharmaceutical houses outperform all other major American industries in net profit after taxes as a percent of stockholders' equity. The drug companies regularly show a return of about 18%, a figure two-thirds higher than the average rate of return for all manufacturing concerns in the decade 1960-1970."

And (1c 163): "Year after year the industry ranks first or second in after-tax income as a percentage of net worth . . . As one economist said in testimony before the Senate Select Committee on Small Business: 'The high profitability reflects the absence of competition; the stability of profits demonstrates the absence of risk to investors.'"

In *U.S.* v. *Chas. Pfizer*, 281 F. Supp. 837 (S.D. N.Y. 1968), rev. 426 F.2d 32 (2nd Cir. 1970), affirmed by an equally divided court 404 U.S. 548 (1972), petitioner Bristol-Myers was a defendant. Production cost of tetracycline was $2.55 (1954), $1.76 (1956) and $1.59 (1958). Yet the selling price to druggists was $30.61 and $51 (R. 161).

[3] U. S. drug manufacturers annually spend $1.2 billion on the advertising and promotion of prescription drugs, nearly four times the amount spent on research and development. Prescription drugs (unlike over-the-counter drugs) advertising and promotion is confined to physicians and occasionally, pharmacists. This is approximately $4000 per doctor per year. This includes the salaries of over 21,000 detail men, each of whom costs the industry $35,000 per year. 229 *The Scientific American* 161, 162 (1973).

[4] *Small Business Problems in the Drug Industry*, Hearings before the Subcommittee on Regulatory Agencies, House of Representatives, 90th Congress, 1st Sess. 197 (1967).

"Sheer magnitude of the price discriminations evident from the record of these hearings would seem to justify vigorous remedial action by the Federal Trade Commission. It is unreasonable to expect the remedy of private anti-trust enforcement by disfavored retail druggists to serve as a sufficient deterrent to drug manufacturers' discriminatory pricing.

"It should be made absolutely clear at this point that the findings of the subcommittee, which have just been stated in no way lead to the conclusion that the solution to the problems raised is to increase the costs to institutional customers to the level of the present costs of retailers. The public interest requires, rather, that the often excessive gap between prices to wholesalers and retailers on the one hand, and institutional customers on the other, should be closed by lowering the price to retailers. Only in this way can those members of the public requiring drugs for the preservation of their health and, indeed, for their very life, buy at prices which do not discriminate against them."

No one has suggested that hospitals curtail their sales to employees, staff, inpatients, outpatients, or the public at large. Respondent's assignors are prepared to meet fair competition providing they can buy at a nondiscriminatory price.

Likewise we have no quarrel if hospitals decide to sell drugs to its staff or employees as a fringe benefit. Such decisions are for the hospital alone. But, respondent does object when the hospital is permitted to buy the same item for much less when it is not

intended for hospital use and consumption but for the private use at home of employees, physicians, families, friends, in-laws, and walk-in strangers.

Respondent has no quarrel whatever with hospitals, but rather with the source of the unwarranted discrimination—the petitioners.

There should be little effect on hospitals, since, as the Court of Appeals noted (Pet. Cert. A6):

> "in-patient and emergency treatment, cover by far the greater part of hospital distribution"

and both are within the 13c exemption (A7).

It Would be Premature to Decide the Issue Finally at this Juncture

The District Court granted summary judgment though respondent had been denied access to many critical facts. Respondent was not permitted to propound interrogatories, requests for admission, motions to produce, or take petitioners' depositions, before the court granted summary judgment.[5] The court even declined—for a time—to enter an order prohibiting documents destruction.[6] The information we did extract came, in the main, from reluctant hospital employees, several of whom were represented by petitioners' attorneys.[7] Even after the order was en-

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[5] R. 46, 126, 276, 282, 311, 322, 325, 326, 328, 339, 340, 361, 372, 373, 374, 425, 427, 438, 439, 440, 442, 450, 454, 461, 465, 471, 502, 506, 544, 552, 555, 556, 641, 700, 701, 702, 728, 842, 937; Tr. 9/11/72 p. 115, lines 16-19, and pp. 118-119; Tr. 11/27/72, p. 21, lines 6-25; p. 22, 1-3.

[6] R. 266.

[7] R. 833.

tered, many petitioners did not notify their employees.[8] Consequently, many documents were destroyed before respondent could see them.[9] Even for the hospital deposed, respondent was foreclosed from several subjects, such as the extent hospitals did ship drugs out of state to undisclosed buyers.[10]

The District Court has not yet permitted respondent to determine if the Sherman Act has also been transgressed.[11] Hence respondent's factual statement here is necessarily foreshortened.

Summary judgment is inappropriate where there are a plethora of material fact disputes as here. Respondent submitted numerous personal knowledge affidavits challenging Petitioners' data.

Petitioners did not challenge respondent's affidavits or submit affidavits or evidence of its own.

Hurtado v. *United States*, 410 U.S. 578, 587-588, fn. 8 (1973) held summary judgment was improper where the government did not support its Answer with affidavits or other evidence.

As in *Adickes* v. *S. H. Kress Company*, 398 U.S. 144, 157 (1970) petitioners failed to show the absence of a genuine issue for the material issues raised by respondent's affidavits.[12]

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[8] Krieger 5, 6; Mason 6, 7; Metz 63; Coffee 5, 7; Connerty 9; Duley 6.

[9] McClintic 75; Mason 6; Metz 97, 109; Coffee 7.

[10] Pirtle 35.

[11] R. 46.

[12] *Arnett* v. *Kennedy*, 416 U.S. 134, 139 (1974) states:

". . . Since the District Court granted summary judgment to appellee, it was required to resolve all genuine disputes as to any material facts in favor of appellant, and we therefore take as true for purposes of this opinion the material particulars of appellee's conduct which were set forth. . . ."

Court of Appeals Decision Misconstrued by Petitioners

Petitioners have misread the Court of Appeals opinion. They have assumed that when the Court held the 13c exemption included inpatients and emergency patients, the court used the word "inpatient" in the most constricted sense.

The terms 'inpatient' and 'outpatient' have different meanings to different hospital administrators.[13]

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[13] Compare the depositions of the following hospital personnel:

Ammon, 6, 8, 10, 19, 20; Bleckinger, 10; Camosso, 6, 36, 42; DeLorimer, 7, 8, 13; Desrosiers, 6; Eldien, 12; Fraser, 4, 5; Graham, 35; Haas, 13; Hanson, 7, 8; Hastings, 9, 10; Hollowell, 7; Johnston, 33; Kaeser, 6; Lindley, 5; Pirtle, 16, 49; Renfrow, 22; Scott (1st), 47; Schulte, 8, 13; Sessler, 4; Shupe, 9, 23; Slick, 10; Smith, 11, 12, 13; Sperry, 7, 8, 13; Steed, 9; Walker, 6, 8; Underriner 4; Wong, 8, 24, 26; Zeasas, 26, 28.

Whether a patient must occupy a bed and/or receive meals at the hospital or stay overnight is a matter of debate between various hospital personnel. Paul Hanson, administrator of one of Portland's principal hospitals, feels that one admitted for day surgery who does not remain overnight, is an inpatient (Hanson, 7, 10). The Chief Pharmacist at another hospital felt that admission for one night was a sine qua non (Bleckinger, 10, 11). Another believed those using the outpatient clinic were inpatients (Camosso, 42). Many hospitals have nothing in writing which spells out the distinction (Schulte, 13; Scott (1st), 47; Sperry, 13). Two hospital officials felt confused (Fraser, 4; Pirtle, 16), while a third was not permitted to answer by his attorney (Zeasas, 26, 28). A fourth felt a stay of more than 12 hours was necessary (Schulte, 8).

Some hospitals regard emergency room patients as inpatients — others do not (Underriner, 4; Pirtle, 16; Shupe, 9; Walker, 6).

The Health Insurance Manual issued by the Department

Even lexicographers seem unable to agree completely.[14]

The Court of Appeals' well reasoned opinion has adopted a rational and pragmatic standard, which can be applied and understood with ease. A careful reading reveals that the court did not hold that all outpatient sales were outside 13c. Rather only those where (Pet. A5):

> "5. They were sold *for home treatment* to outpatients either at hospital pharmacies or at outpatient clinics." (italics supplied)

Thus drugs administered to patients in the hospital or hospital clinics (such as injections or drugs) were covered by the 13c exemption irrespective of the way in which the particular hospital classified such individuals. This is made clear by the court's further statement (Pet. A6):

"There is no dispute that such dispensing of

of Health, Education & Welfare 210 (10-71) regards as an inpatient one who is "formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight. However, there are exceptions to the general rule:

> A. Hospitalization for Minor Surgery—When a patient with a known diagnosis enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep him in the hospital for only a few hours (less than 24), and this expectation is realized, he will be considered an outpatient regardless of: the hour of admission, whether or not he used a bed, and whether or not he remained in the hospital past midnight."

[14] Compare *Webster's Third New International Dictionary*, Unabr. with *Brittanica World Language Dictionary*, and Smith deposition 12.

> drugs in the course of treatment in the hospital is the hospitals' own use."

We agree. A use in the hospital under hospital auspices of a drug acquired by an individual, whether called an outpatient, inpatient or whatever is a use by the hospital. However, a drug purchased from the hospital pharmacy for use outside the hospital by one who is no longer a patient or who never was, cannot logically be regarded by the hospital as "their supplies for their own use".

Petitioners somewhat facetiously (we suspect) insist the Court of Appeals drew the line between an exempt and non-exempt sale on the basis of the angle of the patient receiving the drug. Nothing in the opinion supports this. The opinion makes it very clear it does not matter in the least whether the individual receiving the drug is horizontal, vertical, or diagonal. Neither does it matter whether the patient is occupying a bed or not. No such naiveté can fairly be imputed to the court. Rather the distinction, which the court drew, is the one drawn by the law itself (i.e., "their supplies for their own use"). A day surgery patient receiving medication while being treated in the hospital would be covered whether in bed or not, as would one receiving a shot or pill while standing upright or otherwise in the outpatient clinic, but not one who receives a package of oral contraceptives for use at home.

STATEMENT OF FACTS

A. Discrimination by Petitioners against Drug Stores

The pharmaceutical industry has long been characterized by high concentration, high advertising cost, intense nonprice competition,[15] cross licensing and sales,[16] and frequent absence of meaningful price competition.[17]

Concomitantly, the drug manufacturers (petitioners included) have long discriminated against the generally hapless drug stores and in favor of virtually every other trade and pressure group, and especially hospitals.[18] The motivation for favoring hospitals is apparently to acquaint physicians (especially neophytes) with brand names so they will subsequently prescribe such drugs by brand rather than generically,[19] even though this may ultimately cost the patient double, treble or more.[20]

[15] Department of Health, Education and Welfare, *A Report to the President* 37 (February 1967).

[16] R. 133.

[17] See Appendix A containing (inter alia) excerpts from the hearing on the small Business Problems in the Drug Industry by the House Subcommittee on Activities of Regulatory Agencies, which concluded (H.R. 1983 (1968), p. 77): "There is little or no price competition in the marketing of trademarked pharmaceutical products among manufacturers." Hereafter for brevity, respondent will refer to this hearing as Hearings unless otherwise marked.

In his book "In a Few Hands" 8-10 (1965) Senator Kefauver stated: "Perhaps no more dramatic illustration of the effect of monopoly on the consumer can be found than in the drug industry . . . In the various categories of drugs examined by the Subcommittee, prices of the major companies were identical, often to the last decimal . . .

". . . most drugs are actually manufactured and sold in bulk form by two or three producers — sometimes only one. All companies, large or small, that market the product buy the drug in bulk form from these sources."

[18] See pp. 14-16, infra.

Witnesses before the Subcommittee to the Select Committee on Small Business of the House of Representatives described the variegated pricing modes of drug manufacturers as chaotic,[21] startling,[22] and rampant with "wheeling and dealing".[23] Another long time wholesaler told the committee (1c 297):

> "I know of no other business that has so many different prices. I know of no other business where the cost of raw material is so negligible in relationship to the selling price of the finished product."

The final report of the Subcommittee of the House of Representatives contained the following chart (H. R. No. 1983, 90th Cong, 2d Sess, 10):

[19] Hearings, Ibid., p. 43; House Report 1983, 90th Congress, 2nd Session, 10, 19, 34, 37, 67, 68; Connerty deposition, 17, 20.

[20] Hearings, Ibid., 50 (even a ten-fold variation at times), 151, 269, 279, 298 ('if you take certain trademark drugs, . . ., the one that sells at $22.60 is commonly sold under its generic name for anywhere from 75 cents to $1.25'); 411 (on occasions the same manufacturer will produce the same drug under generic labels to compete with its own brand name product).

Despite the inanity of ordering the identical product by its brand name, instead of generically, when the comparative cost may be far higher, roughly 90% of the drugs are prescribed by brand names (Ibid. 277).

[21] Hearings, supra 260.

[22] Report of the same committee, H.R. No. 1983, p. 31.

[23] Ibid., p. 317.

COMPARATIVE PRICES CHARGED HOSPITALS AND RETAIL DRUGGISTS

Drug	Quantity	Price to Hospitals	Price to Druggists
Amphycillin	100	$11.96	$27.25
Dilantin	1000	7.00	9.30
Diuril	1000	30.00	48.45
Equanil	500	11.30	29.00
Gantrisin	1000	9.00	29.30
Ilosone	100	16.64	21.99
Librium	500	23.95	27.75
Melleril	100	6.40	7.50
Neomycin	100	5.20	20.54
Notec	100	2.00	4.08
Peritrate	500	25.50	30.00
Steclin	100	4.95	5.50

Other of discriminations appear in Appendix B. Doubtless still others could be uncovered if we are given an opportunity. Though this case has been pending more than four years, respondent has not yet been permitted to ask petitioners or the hospitals what prices were charged the nonprofit hospitals. (See supra, p. 7).

In addition some petitioners discriminated against drug stores in favor of hospitals in the following respects:

(a) free goods;[24]

(b) 'hospital size' packages of drugs (some at

[24] Hearings, supra, 71, 86, 129, 136, 143 ("unequivocally"); Connerty, 20, 26; DeLong 55; Duley (1st), 37 (though sometimes called, euphemistically, "starter dose(s)"), Krieger, 11, 12 (though some manufacturers prefer to refer to such free goods as gifts to the doctors in the hospital, rather than gifts to hospital doctors); Metz, 17, 50, 103.

considerable savings) are made available to hospitals and to no one else;[25]

(c) some items are sold only to hospitals, but not drug stores;[26]

(d) quantity purchase ceilings are sometimes imposed on drug stores (or on wholesalers through whom they must sometimes buy), but not hospitals;[27]

(e) some petitioners refuse direct sales to drug stores, but not hospitals;[28]

(f) quantity discounts ostensibly do not favor hospitals, but practically speaking do because they are often out of the practical reach of drug stores.[29]

[25] Hearings, supra, 64, 248, 274, 286; R. 132, 147; House Report No. 1983, 90th Cong., 2d Sess. 7, 11, 34, 39; Connerty, 19, 21, 36, 46, 52; Duley, 78, 80; Krieger, 61, 64, 67, 74.

[26] Hearings, supra, 111; R. 136; House Report No. 1983, 90th Cong, 2d Sess 18, 19 ("A community pharmacy that is unable to buy certain products, it seems, is placed at a great competitive disadvantage with one that is not so restricted").

[27] Hearings, supra, 201, 219, 321; House Report No. 1983, 90th Cong. 2d Sess. 23, 38; Connerty, 48, 49, 50, 51.

[28] Hearings, supra, 74, 111, 142, 143, 273; R. 105-6, 123, 143, 292, 377; House Report No. 1983, 90th Cong, 2d Sess, 59; Connerty 45; DeLong 88; Hannon, 11, 24; McConnell, 9, 10, 12; Mason 11; Winther 4; Zeasas 14.

[29] Hearings, supra, 72, 315, 516; House Report No. 1983, 90th Cong, 2d Sess 50, 54, 55 (committee counsel observed "that the mommas and poppas of the industry cannot afford to start 5 or 10% behind Mr. Dart and Mr. Drug Fair and Mr. Peoples and hope to survive". This remark is also applicable to hospital competition too); Clifford, 13, 20, 23 (such quantity discounts do not appear in the Lilly catalogue, and would not be shown to a neighborhood pharmacy unless there were a special request); Coffee, 57, 59, 67; DeLong, 66, 67, 70; Duley (1st) 47; Kobelin 29; Kreiger, 50, 61

(g) handling charges are imposed at times on drug stores but not hospitals;[30]

(h) drug stores are not always permitted to buy the more popular brands;[31]

(i) extra time for payment is granted by petitioner Warner to direct purchasing hospitals, but not drug stores.[32]

There is little indication petitioners make the slightest effort—or cared—what disposition hospitals made of the drugs. Some—such as oral contraceptives—were patently never intended for use or consumption within the hospital.[33]

B. Aftermath of Hospital Discrimination

Having acquired the drugs under 13c at substantial discounts, ostensibly for "their own use", the favored Portland hospitals soon began sales for consumption or resale outside the hospitals to one or more of the following:

(a) employees and their families, parents, and even in-laws.[34]

(hospital package quantity price is not listed in Warner's retail pharmacy pricelist for September 1974 since this is a special hospital packet available for hospital use only); Metz 19 (discount quotations were not offered by Bristol to neighborhood pharmacies but only to hospitals), 36-38.

[30] R. 730.

[31] House Report No. 1983, 90th Cong, 2d Sess 18.

[32] Ibid 36, 37.

[33] Ibid 43.

[34] R. 794, 221, 222, 223, 263, 298, 319, 457, Ammon 18; Camosso, 26, 30, 21; Chartier, 7, 8; DeLorimer 16; Desrosiers, 10, 11, 13; Eldien 5; Fawkes (1st) 24, 26, 38; Ferrell 7; Fraser 10; Graham 21; Hollowell, 7, 8, 15, 16, 19; Johnston, 4, 19, 21, 22; Kaeser, 5, 31, 33, 37, 43; Matlick, 8, 9, 11; Neal 4; Renfrow 15; Schulte 12; Sessler 8; Kaeser 50; Lindley, 6, 8, 9-11; McConnell, 17, 24, 29, 32; Mack, 9, 11; Shupe, 5, 11, 28, 29, 32; Slick, 12, 17, 18; Smith 18; Sperry 8; Steed, 7, 12; Stocks, 6, 9; Wong, 9, 11, 20; Zeasas, 17, 18, 21.

(b) staff doctors for their personal, family, and office use;[35]

(c) volunteers, students, pensioners and clergy;[36]

(d) take-home drugs (also called, "Go Home Meds") to patients upon discharge for use at home;[37]

(e) walk-in individuals, who had no connection with the hospital;[38]

[35] R. 398, 419; Ammon, 18, 20; Bremner 11; Eldien, 5, 12; Fawkes (1st) 4, 23, 26; Fawkes (2nd) 29; Graham 21; Haas, 8, 16; Hastings 20; Hollowell, 7, 8; Johnston 4; Matlick 9; Sessler 8; Lindley 11; McConnell 24; Smith 18; Sperry 8; Steed 12.

[36] R. 795, 398, 419; Ammon 20; Fawkes (2nd) 29, 30; Kaeser 35; Zeasas 21.

[37] R. 398, 420, 455, 456, 471, 472, 643, 645, 711, 713, 791, 792; Ammon, 23, 25; Chartier, 5, 6, 11, 18, 19; DeLorimer 13; Eldien, 11, 12, 14; Fawkes (1st) 19; Gustafson 16; Haas, 7, 8, 17, 19; Hastings, 13, 15; Kaeser, 6, 44; McConnell, 23, 24, 37; Matlick, 13, 14; Neal, 4, 9; Pirtle 14; Renfrow 8; Schulte, 19, 20; Sessler, 7, 11; Shupe, 29; Slick 20, Smith, 13, 15; Walker, 15; Wong, 7; Zeasas, 15, 18.

[38] Hearings, Small Business Problems in the Drug Industry, Subcommittee on Activities of Regulatory Agencies of the Select Committee on Small Business, House of Representatives, 90th Cong, 1st Sess. 24, 138; R. 126, 345, 378, 458, 460, 461, 476, 645, 940; Bremner, 9, 26; Camosso, 6; Fawkes (1st) 4, 9, 26, 33; Fawkes (2nd) 30; Graham, 28, 55 (somewhat higher sales during fishing season, of seasick pills); Gustafson, 6; Haas, 9; Kaeser, 5, 6, 15, 35, 44; Lindley, 6, 8, 13 (not to his knowledge has a pharmacist at North Clackamas Hospital ever refused to fill a prescription that is legitimate to the general public); McConnell, 20, 23 (no restrictions on over-the-counter drugs), 44; Mack, 10 (there is no policy at Gresham Hospital prohibiting the general public from the hospital pharmacy); Sessler, 5, 6, 12, 19; Walker, 9; Wong, 20; Zeazas, 4, 15.

(f) as refills of those prescriptions covered by (a), (b), (c), (d) and (e) above;[39]

(g) to other hospitals, clinics and even drug stores;[40]

(h) mail order sales to those writing the hospital from their homes;[41]

(i) to all members of a particular union and without limit, and whether ill or otherwise.[42]

C. Extent of Hospital Resales to Nonhospitalized Individuals is Huge, and Easy to Determine

At various times petitioners have disavowed any reliance on the de minimis defense.[43] However, since they seem to have resurrected it here, it should be stressed that the quantum of sales to nonhospitalized individuals for use at locations remote from the hospital was immense.

It is relatively easy to determine the numbers.

"Prescription" refers only to drugs not intended to be used within the hospital.[44]

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[39] R. 332, 891, 938, 941; Camosso, 12, 13; Graham, 27; Haas, 15, 16; Pirtle, 15, 40 (the refill ratio has been approximately 40%); Winther, 10.

[40] Bremner, 21; Chartier, 15; Gustafson, 4; Haas, 14; McConnell, 29; Metz, 3, 74, 75, 77, 78, 80; Pirtle, 21, 22; Desrosiers, 13; Eldien, 7; Fawkes (1st) 15, 16; Fawkes (2nd) 8; Graham, 43; Haas, 14; Johnston, 18; Kaeser, 50; Zeasas, 20.

[41] Greenlick dep. ex. no. 3, Johnson and Christensen, *A Report of the Kaiser Foundation Drug System* (1971) 299.

[42] R. 369, 470; Ferrell, 11; Swope, 3 (Local 1092, Retail Clerks, is under such an agreement. It has just under 7,000 members, making it the largest local in Oregon).

[43] R. 797, 833.

[44] Or. Rev. St. 689.010(3) and (5); 689.170; 689.825; Zeasas, 9; Fawkes (2nd) 15; Shupe, 5.

All drugs leaving the hospital must have a prescription number and be filled by a licensed pharmacits.[45] Prescription refers to a drug used by one no longer a hospital patient or who was never a patient, for consumption at a location other than the hospital.[46] A drug given to a patient in the hospital is called a 'hospital order'.[47]

The extent of sales to nonpatients is substantial.

One hospital in Portland to whom petitioners made discriminatory sales filled 216,958 prescriptions for nonhospitalized individuals between December 26, 1967 and May 8, 1973.[48] Another, 231,061 between July 1, 1970 and April 12, 1973. A third filled 49,435 new prescriptions between March 29, 1969 and March 16, 1973. A fifth, 38,045 between March 15, 1971 and March 9, 1973. A sixth, 17,803 between February 2, 1971 and February 2, 1973.[49] At another hospital the numbers of prescriptions (which necessarily means the individual is not or was never a patient) were (R. 272):

3/1/70 to 12/31/70	279,151 prescriptions
1/1/71 to 12/31/71	409,790 prescriptions
1/1/72 to 9/30/72	343,626 prescriptions

Furthermore, there is reason to believe the extent of hospital sales to those who are not — or never were — hospital patients is larger than conceded. An in-

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[45] Ibid. R. 716.

[46] Ibid. Fawkes (2nd) 15; Shupe, 5.

[47] Ibid.

[48] R. 832.

[49] R. 744, 746, 897.

vestigator was able to make purchases of prescription drugs at eight of the fourteen Portland area hospitals without difficulty though not a patient or ill, despite their subsequent denials.[50]

Not infrequently petitioners charge wholesalers more than they charge hospitals.[51] Despite this, some petitioners still insist that drug stores buy through wholesalers and not direct.[52] To exacerbate matters, most pharmaceutical manufacturers recently cut discounts to wholesalers, thus virtually mandating a raise in their selling prices to drug stores.[53]

The hospital generally resell the drugs to their own officers, employees and staff doctors at lower

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[50] R. 343-347.

[51] Hearings, Small Business Problems in the Drug Industry, House of Rep 90th Cong, 1st Sess, Subcommittee on Activities of Regulatory Agencies 248 (Jack Mandell, one of New York's largest wholesalers, testified: "it is prevalent in the drug industry, by some manufacturers, to sell to hospitals at prices far below what a wholesaler will buy it at.")

See also: R. 308 (Robins sells to wholesalers at discounts of 16-2/3% and to non-profit hospitals at a 20% discount); Coffee, 41, 59; DeLong, 60; Koss, 8; McClintic, 36; see also Connerty, 38; H. R. No. 1983, 90th Cong, 2d Sess, 9 ("The subcommittee received testimony to the effect that drug manufacturers sell their product to hospitals at phenomenally low prices which are often below cost. A witness cited the following specific example: A pharmacist who wants to buy a bottle of 500 Equanil tablets, which is a trade name for meprobamate, 400 milligram tablets, will pay *$29 for the 500*. Hospitals are in a position to buy this product in units of a *thousand* tablets to the bottle for *$22.60")*. The report also quoted (1c 9) from the *Indiana Pharmacist* of December 1965 as follows: "There seems to be universal agreement that the pricing system currently in use by most of the pharmaceutical manufacturers is often inconsistent, unfair, and generally chaotic."

[52] Footnote 26.

[53] Hearings, supra, 296.

prices than those charged hospitalized patients.[54]

Fourteen Portland hospitals have more than 10,000 employees,[55] not including their families. There were 2,500,000 plus full-time hospital employees nationally in 1971.[56]

Not infrequently a higher price was charged inpatients than that charged outpatients or off-the-street customers.[57] Thus, hospitals were able to mark up the price and generate substantial profits, and still resell to nonhospitalized persons at lower prices

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[54] R. 113, 398, 550; Camosso, 32, 33; Chartier, 10; DeLorimer, 16; Desrosiers, 10, 11, 13; Eldien, 5; Fawkes (1st) 23; Graham, 21; Gustafson, 4; Haas, 8, 21; Hanson, 11; Johnston, 19, 21; Kaeser, 30, 33, 37; Matlick, 11, 15, 18, 19; Neal, 4; Renfrow, 15; Schulte, 12; Sessler, 8; Lindley, 9, 11; McConnell, 17, 29; Mack, 9; Wong, 11; Zeasas, 21.

[55] Stocks, 10.

[56] Knowles, The Hospital, *Scientific American* (Sept. 1973), 128, 133.

[57] Chartier, 8; Eldien, 9-10; Ferrell, 8; Pirtle, 18; Ibid., fn. 41.

As explained to the House Committee by Edward Bopp, president of the Louisiana Pharmaceutical Association (Hearings, supra 141):

> "Gentlemen, you can readily understand the unfair disadvantage a drugstore retailer occupies in competing with a dispensing pharmacy and hospital-clinic purchasing the same merchandise at 15 to 20% less than can be purchased by said retailer. The general pricing practice of hospital-clinics may be to mark prescription drugs from cost indicating the retail community pharmacy is being markedly undersold. Therefore, you procure a bad image in said community and are identified as a commercial profiteer steadily forefeiting consumer business."

As he further explained (1c 139):

> "In the case of outpatients, their prices must be competitive with the druggists, but with the captive audience, the inpatients, they do not have competition."

than drug stores must charge to economically survive.[58]

In the meantime, the drug store pharmacist, who is struggling to survive but is treated by petitioners as the industry wallydrags, is made to look bad because there is no way he can match the prices charged by the favored hospital pharmacy to outpatients and casual drop-ins. As explained to the House committee by Hyman Moore, a major drug wholesaler (Hearings, supra 318-319):

> "There is something available to everybody I can think of to get a good price on their merchandise except the average corner pharmacist. He is the one who is being made to look like the price gouger and it is not so. There are just darned few rich retail druggists."

D. Effect of Discriminatory Pricing has been Disastrous to Drug Stores

Armed with the leverage of discriminatory prices, the inevitable occurred. In opening the Congressional hearing, Chairman Dingell observed (Hearings, supra, 1st Sess (1967), p. 1):

> "In the distribution of drugs, however, the small business wholesaler and particularly the retailer contribute much to the task of insuring ready access by all our people to their lifegiving products.

[58] Ibid; Hearings, supra 137 (markups as high as 800% were described to the committee) R. 456, 484; Desrosiers, 22, 23; Fawkes (1st) 13; Haas, 6; Hollowell, 16-17; Kaeser, 28, 30; McConnell, 29, 31; Matlick, 15; Pirtle, 31; Renfrow, 47; Shupe, 14, 17; Sperry, 9; Winther, 7; Zeasas, 13.

> "In recent years there has been a continuing decline, both in market share, as well as actual numbers, in the independent sector of the industry."

While hospital drug sales have increased steadily (see chart at back of brief), the ranks of the drug stores have been correspondingly thinned, and their net profit margins have been eroding for years.[59] At the same time manufacturers' sales and profits have grown with almost monotonous regularity.[60]

As stated in the final report of the House subcommittee:[61]

> ". . . there is here something of a paradox that manufacturers' profits should be at an alltime high while wholesalers' and retailers' profits are declining—that the public's cost for drugs has more than doubled per prescription and has increased more than sixfold in terms of dollar volume—yet, retailers report that they are all too often encountering problems in terms of profitability."

In Portland more than half the drug stores have closed within the past ten years.[62] Concomitantly hos-

[59] H.R. 1983, 90th Cong, 2d Sess. 40-41 (1968).
[60] Ibid, 41.
[61] Ibid.
[62] The closures of neighborhood drugstores in Portland from 1954-1972 are as follows (R. 541): 1954—2; 1955—1; 1956—0; 1957—2; 1958—0; 1959—0; 1961—4; 1962—1; 1963—8; 1964—2; 1965—7; 1966—8; 1967—8; 1969—6; 1970—11; 1971—7; 1972—7.
Inadvertently omitted was 1968 from R. 541. However, the correct number was 5 closures in 1968. (Plaintiff's Sept. 15, 1975 certificate in support of amended complaint filed in the district court).

pital sales have boomed.[63] The points of closure are also revealing. The locations most acutely affected are those closest to the hospitals as reflected in the three maps in the folder at the back of this brief. Even more abysmal are the prospects ahead for drug stores unless the Robinson-Patman Act is enforced. Portland's Kaiser Hospital has made a projection of

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The rate of attrition of neighborhood pharmacies appears to be a national phenomena as well. Testimony before the House Committee revealed that (H.R. No. 1983), 90th Cong, 2d Sess.):

(a) in Philadelphia there were 1400 drugstores owned by pharmacists in 1945. In 1967 there were only 800, and it was predicted that the number could contract further to 700 or perhaps even 500 (1c 11);

(b) in Maryland 8 independent drugstores were forced to close their doors in the three months prior to the hearing in 1967 (1c 17);

(c) in the Bronx during a 10-12 year span, the number of drugstores has declined from 600 to 400 or so. (Hearings, supra, 160, 185);

(d) in Massachusetts during a ten-year period 100 neighborhood pharmacies have closed (Hearings, supra, 60).

An article in The Oregonian (Sept. 16, 1975, p. B-2) states that "Illinois has been losing 30 pharmacies a year for 10 years."

[63] Drug sales at the various Portland hospitals which have been mentioned have grown from $568,871 (1966) to $881,880 (1971) at Emanuel; from $518,748 (1967) to $885,562 (1972) at Good Samaritan; from $247,754 (1967) to $318,337 (1972) at Holladay Park; from $238,466 (1967) to $389,862 (1972) at Physicians and Surgeons; from $322,157 (1966) to $492,550 at Portland Adventist; from $197,900 (1967) to $245,762 (1971) at Portland Osteopathic; from $339,678 (1966) to $640,286 (1971) at Providence; from $419,815 (1966) to $630,282 at St. Vincent; from $62,590 (1966) to $295,275 (1972) at Tuality Community; from $54,007 (1965) to $263,274 (1972) at Willamette Falls; from $36,211 (1967) to $69,944 (1972) at Willamette Methodist; and from $250,720 to $1,447,575 (1971) at Bess Kaiser (R. 866-7 and chart infra). (Earlier figures were not available for the other two hospitals.)

its future drug sales. Its study revealed sales of 57,100 prescriptions in 1960 and 315,100 in 1969. It anticipates 1980 sales of 590,000, if all other factors remained fairly constant.[64] Using more optimistic projections the total is 744,000-779,100.[65] If the "capture rate" (Kaiser's term for the percentage of patients who consulted Kaiser doctors, who had their prescription filled at the Kaiser Hospital pharmacy) were to be raised to 100%, then Kaiser estimates sales for 1980 of 1,682,000 prescriptions.[66] If Kaiser succeeds in this even partially, there will be few sales left for the drug stores.[67]

E. Simultaneously Profit Margins have been Substantial at Hospital Pharmacies

While Portland's drug stores have been decimated, net drug profit margins at 12 of Portland's 14 hospitals have varied from 28.8-60.53% (R. 444).[68]

F. The Extent of the Problem is Intensifying. Hospital Resales to Nonpatients are Capturing Larger and Larger Market Share.

Certain demographic trends have also been noted

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[64] Ibid., Fn. 41.

[65] Ibid., 193-195.

[66] Ibid., 198A. (An increase in the "capture rate" is apparently a primary desideratum of Kaiser, if one can read between the lines of this survey).

[67] Illustrative of the impact of an additional 275,000-1,300,000 sales by Kaiser Hospital, might be seen in the sales of the Bel Aire Pharmacy, a typical Portland pharmacy and one of the assignors. In thirteen months Bel Aire filled 9,826 new prescriptions, an average of 756 per month (R. 543).

[68] The profit margin at the 13th was 9.85%, while the 14th did not have the figures (R. 444).

nationally, though not all have yet impacted on the Portland area:

(a) emergency rooms often serve the same function as doctors' offices (especially on the weekends when many doctors cannot be reached) for nonacute medical care;[69]

(b) more and more doctors have moved their offices closer to or into the hospital. Many of their nonhospitalized patients obtain their prescriptions at the hospital pharmacy;[70]

(c) several hospitals have amalgamated some or all of their operations, while others have merged altogether;[71]

(d) some hospital pharmacies are now operated by concessionaires, including chain stores in some parts of the U.S.,[72] (though not in Portland as yet);

(e) satellite clinics have been opened by several hospitals at locations remote from the hospital. Some of these (including Kaiser) have offices for physicians but no beds for patients;[73]

(f) hospitals have been filling larger and larger

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[69] Bodenheimer, Patterns of Am. Amb. Care, *VII Inquiry* 26, 33, (Sept. 70).

[70] R. 132, 547, 653; House Report No. 1983, 90th Cong., 2d Sess. 34, 47; Chartier, 10; Smith, 19.

[71] Brodie & Graber, Institutional Pharmacy Practice in the 1970's, *28 Am Journal of Hospital Pharmacy* (1971) 240, 241; Camosso, 3.

[72] Hearings, supra 13. (In Los Angeles, Daylin, Inc., a large retail drug discount chain has plans to take over pharmacies at Doctors Hospital, Westside Hospital, and Hawthorne Memorial Hospital); Brodie & Graber, Institutional Pharmacy Practice in the 1970's, *28 Am. Journal of Hospital Pharmacy* (1971) 241.

[73] Brodie & Graber, supra, 241.

percentages of prescriptions as compared with neighborhood pharmacies.[74]

SUMMARY OF ARGUMENT

The 13c exemption is limited by its terms to purchases by nonprofit institutions, including hospitals, of "their supplies for their own use"—and should be so construed, and not judicially amended or repealed.

The 13c exemption is construed strictly. It should not be used as to destroy competition. It does not apply when a hospital uses the drugs, food, etc., acquired at discriminatory prices, for non-hospital uses.

The House Subcommittee which investigated this agrees that 13c applies only to intrahospital uses, as did the Court of Appeals.

Words are construed in their ordinary and usual sense. The word "use"—especially the words "for their own use" — refers to consumption by the hospital, and not for resale to others. "Supplies" normally connote things intended for use by the person supplied and not for a subsequent resale. 13c does not apply to purchases for subsequent resale.

Other legal authorities are in accord with the Ninth Circuit decision here.

Congressional purpose will be defeated if hospitals are permitted to obtain drugs at discriminatory prices

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[74] An article in the *American Druggist* (August 9, 1971) states that the percentage of prescriptions filled by hospitals had risen from 34% (1965) to 42% (1970) (R. 680).

for nonhospital uses. 13c was passed so that hospitals might care for charity patients in hospitals at reduced cost. Since its passage the amount of charity extended by hospitals has contracted — not expanded — to the point of extinction in some hospitals.

When 13c was passed in 1938, there were few sales by hospitals to nonhospitalized persons. Normally statutes are construed with reference to the circumstances which existed at time of passage. Statutes are not modified or repealed except by the enacting body.

Take-home drugs are not covered by 13c, since they are not intended for the hospital's own use, but for the private use of an individual at home who is no longer hospitalized.

Employee and physician drug purchases for their personal or family use at home are not supplies used by the hospital.

The standard enunciated by the Court of Appeals is logical and in keeping with the express language of 13c. It can also be administered with ease.

Drug stores should be preserved and are superior in many respects to hospital pharmacies. The consumer should be given the option.

The final destination of hospital profits from drug sales is irrelevant.

The de minimis defense cannot apply where the amounts involved are enormous, as here.

ARGUMENT

I. Construction

A. The 13c exemption is limited to purchases by nonprofit institutions of "their supplies for their own use" — and should be so construed.

Detached from the petitioners' political and sociological arguments, the basic legal issue here is not complex.

The Nonprofit Institutions Act exemption is not obscure, i.e.:

"their supplies for their own use."

Petitioners would like some language added so it would say:

"their supplies for their own use or for the private use of the hospital's employees, staff doctors, and patients (both inpatients and outpatients and their families)[75] at their respective homes."

The amicus (AHA) seeks to amend the entire Act judicially, so it would read:

"if the majority of the supplies acquired are used for hospital uses then the Robinson-Patman Antidiscrimination Act shall not apply."

AHA reiterates one phrase it wrenches out of context from *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212, 217 (9th Cir. 1967), viz:

"the primary purpose".

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[75] There is some doubt whether petitioners still contend families are covered by 13c. See p. 4, supra.

Acceptance of this test, in lieu of the unambiguous one used by Congress, would mean that if 51% of the supplies acquired by a hospital from a manufacturer were for hospital uses, the other 49% could be employed in any way the hospital chose. A hospital could, for example, use the other 49% to open one or more retail drugstores at a location remote from the hospital, using its discriminatory prices to slash whatever remained of the market. In fact, Portland's Kaiser Hospital is doing just that with its six clinic pharmacies scattered throughout the Portland area miles from the hospital in many cases. They sell indiscriminately to one and all.[76] It is not even necessary to be a Kaiser member to buy at thees pharmacies.[77]

B. § 13c construed strictly and to protect competition.

The antitrust laws, and the Robinson-Patman Act in particular, are construed broadly, while exemptions are construed strictly and in favor of competition. *Federal Maritime Commission* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1963); *Perkins* v. *Standard Oil Company of California*, 395 U.S. 642, 647 (1969); *U. S.* v. *McKesson and Robbins*, 351 U.S. 305, 316 (1956).

The Robinson-Patman Act was enacted in 1936 to curb and prohibit all devices by which larger buyers gained discriminatory preferences over smaller ones by virtue of their greater purchasing power. *Federal*

[76] R. 274, 456, 478, 481, 538.
[77] Ibid.

Trade Commission v. *Fred Meyer, Inc.*, 390 U.S. 341, 349 (1968).

The Act is remedial. Such statutes are broadly and liberally construed to effectuate their purposes. *Peyton* v. *Rowe*, 391 U.S. 54, 65 (1968); *Tcherepnin* v. *Knight*, 389 U.S. 332, 336 (1967).

Antitrust immunity is not favored, (*United States v. National Association of Securities Dealers, Inc.*, — U.S. —, 95 S. Ct. 2427, 2443 (1975)) or lightly implied. *United States* v. *First National City Bank of Houston*, 386 U.S. 361, 368 (1967); *Goldfarb* v. *Virginia State Bar*, — U.S. —, 95 S. Ct. 2004, 2013 (1975).

In the absence of an unmistakable directive, the Court has refused to construe legislation aimed to protect a certain class in a fashion that contravenes the goals Congress clearly intended. *NLRB* v. *Plasterers' Local Union No. 79*, 404 U.S. 116, 130 (1971); *FTC* v. *Fred Meyer, Inc.*, supra, 1c 349.

The § 13c exemption is to be read in harmony with the purpose of the Robinson-Patman Act and to extend only to practices plainly within the exemption. *McDonald* v. *Thompson*, 305 U.S. 263, 266 (1938).

Like other excepting clauses, it is to be narrowly construed. *United States* v. *Scharton*, 285 U.S. 518, 521-522 (1932); and *Piedmont & Northern Railway Co.* v. *I.C.C.*, 286 U.S. 299, 311, 312 (1932).

Section 13c should not be read in isolation. In expounding a statute the Court is not guided by a single

sentence or part of a sentence, but rather the whole law, its object and policy. *Philbrook* v. *Glodgett*, — U.S. —, 95 S. Ct. 1893, 1898 (1975).

In construing an exception to a general statute, any doubt is to be resolved in favor of the general provisions, rather than the exceptions. *State* v. *Wright*, 84 Wash. 2d 645, 529 P.2d 453, 458 (1974).

Section 13c is an express exemption for a hospital's 'own use', hence an additional expanded exemption by implication for 'resale' is not favored. As stated in *Colorado Public Interest Research Group, Inc.* v. *Train*, 507 F.2d 743, 747 (10th Cir. 1974), cert. granted June 2, 1975:

> ". . . where the legislature has acted to except certain categories from the operation of a particular law, it is to be presumed that the legislature in its exceptions intended to go only as far as it did, and that additional exceptions are not warranted."

Section 13c uses a combination of finely honed words evidencing a legislative intent to restrict the exemption. The court must give effect, if possible, to every word of the exemption. *United States* v. *Menasche*, 348 U.S. 528, 538-9 (1955).

Congress is presumed to have used no superfluous words and courts are to accord a meaning, if possible, to each word used. *Platt* v. *Union Pacific R.R. Company*, 99 U.S. 48, 58 (1879).

Hospitals that resell drugs for off-premises consumption are competing with drug stores at the

same functional level. *United States v. McKesson and Robbins, Inc.*, 351 U.S. 305, 313 (1956).

Drug sales to hospitals that compete at the same functional level with drug stores are subject to the Robinson-Patman Act.

Federal Trade Commission v. *Sun Oil Company*, 371 U.S. 505, 520 (1963) held in construing the Robinson-Patman Act:

> "* * * Congress intended to assure, to the extent reasonably practicable, that businessmen at the same functional level would start on equal competitive footing so far as price is concerned."

The § 13c exemption does not protect hospital drug sale practices that compete at the same functional level, for when hospitals engage in retail selling to nonhospitalized customers they are then competing directly with drug stores. *Clairol Incorporated* v. *Federal Trade Commission*, 410 F.2d 647 (9th Cir. 1969).

Petitioners argue that 13c should be extended to include situations where there is direct competition between hospitals and drug stores. Otherwise, petitioners argue, there was no reason to pass 13c in the first instance. However, petitioners overlook that in 1938 it was believed by hospitals (and drug manufacturers too, apparently) that the 1936 Robinson-Patman Act had prohibited "special prices" to hospitals.[78]

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[78] H.R. 2161, 75th Cong., 3rd Sess. (1938), quoting letter from the President of the Hospital Bureau of Standards and Supplies. This letter was quoted in both House and Senate reports. See A12-13, 15, Res. Br. in Opp.).

There was also considerable debate—and still is to a degree—among the antitrust bar with respect to the precise scope of functional discounts which are allowable under Robinson-Patman.[79]

13c was meant to clarify this point with respect to hospital purchase for intrahospital use. But, it was never intended to countenance a mass invasion of the retail drug sale market by hospitals. Rather as the Senate report noted:[80]

> "The purpose of the Robinson-Patman Act, to prohibit price discrimination between purchasers in interstate commerce where competition would thereby be lessened, does not seem to apply as to eleemosynary institutions as they are not operated for profit. The act does forbid such favors as might be granted by sellers to such institutions."

Similarly the House report noted:[81]

> "The Robinson-Patman Act prohibits price discriminations between purchasers in interstate commerce . . . where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition.
>
> "The committee does not feel that the wholesome purpose of the Robinson-Patman Act will

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[79] Patman, Complete Guide to the Robinson-Patman Act 23-25; Edwards, The Price Discrimination Law, 286.

[80] S.R. 1769, 75th Cong., 3rd Sess., quoted A14-15, Res. Br. in Opp.

[81] Footnote 78.

> be interfered with by the enactment of this bill to make certain that favors in price which are occasionally extended to eleemosynary institutions, because of the character of the institution, do not fall under the ban of the act."

It seems clear that Congress had in mind the role traditionally occupied by hospitals, and not the form of business buccaneering which petitioner and AHA contemplate.

C. 13c exemption does not apply when a hospital does not use drugs, food, etc. for hospital uses.

Respondent should again mention—since petitioners repeatedly seek to cast us in the role of the heavy in some sort of imaginary anti-hospital drama—that respondent has never suggested what disposition a hospital should make of the drugs it acquires. This is an intrahospital affair. But *we are concerned when a hospital acquires drugs at a price which discriminates against drug stores and then chooses not to use them for a hospital purpose, but decides to conduct an operation which cannot be distinguished—save for location—from that conducted by a drug store pharmacy.* Such acquisition can only be regarded as unfair competition.

D. The house subcommittee agrees that 13c applies only to intrahospital uses — as did the court of appeals.

The House Subcommittee, which investigated this identical problem, concluded (House Report No. 1983, 90th Cong. 2d Sess. 78-79):

"The Nonprofit Institutions Act of 1938 is designed to afford immunity to private nonprofit institutions (like hospitals so organized), from the prohibitions of the Robinson-Patman Act to the extent the sales are for the non-profit institution's 'own use'. The Nonprofit Institutions Act does not apply to institutions organized for profit.

"When a profit or a nonprofit hospital purchases drugs for its 'own use', this purpose is for a different function, i.e., unit doses for hospitalized patients rather than for resale at the retail drug distribution level. In such 'own use' purchases, at least in the contemporary climate of drug distribution in the United States, the hospital is not thereafter competing with retail druggists, because of such functional difference. Conversely, when the drug sales are not for such hospital's 'own use', but rather for general consumer resales, the institution is competing with the retail druggist because it is functioning in a competitive sense just like a retail druggist.

"This same result occurs when a 'for-profit' health care institution buys drugs for its 'own use' on one hand, or retail drug sales on the other hand. The Robinson-Patman Act is concerned with the realities of competition, not labels. (Federal Trade Commission v. Simplicity Pattern Co., 360 U.S. 55 (1959)).

"There is no basis apparent from the record why the mandate of the Robinson-Patman Act should not be applied to discriminatory drug sales favoring nongovernmental institutional purchasers, profit or non-profit, to the extent there is prescription drug competition at the retail level

with disfavored retail druggists. Consumer interests are compromised by permitting drug price discrimination in the area because the retailers and consumers ultimately must pay higher drug prices as a form of economic subsidy to the drug supplier for the lower prices which that drug supplier charges the institutions.

"To be sure, there may be a gray area in determining where own-use purchases leave off and retail competition begins with the private institutional health-care purchaser. This gray area centers on so-called outpatient dispensing by health-care institutions. While the term 'out-patient' is not susceptible of one simple definition which embraces all hospitals, the following factors appear to apply:

"(1) An 'outpatient' is a person who, although receiving hospital services, is not a confined, hospitalized patient;

"(2) The outpatient, by virtue of not being hospitalized, presumably has the physical mobility to purchase prescription drugs from retail sources other than the hospital;

"(3) Hospital drug sales to physically mobile outpatients therefore should be recognized as straightforward retail sales in direct competition with any other retail druggists in the community. The outpatient may be a captive customer or patient of the institution for other health-care services, but because of mobility, the outpatient is capable of se-

curing his prescription needs in the community."[82]

The same point was succinctly put by Judge Merrill in this case when he stated (510 F.2d 486, 489):

"Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of inpatients or emergency patients. The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer.

"The hospitals here are (quite properly) accommodating patients, staff and strangers with means whereby they can conveniently purchase for their use. The question is not whether the hospitals can continue to provide this useful community service. The question is whether in providing it they may acquire the drugs for such resale at an acquisition price that discriminates against local retail druggists. We hold that they may not."

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[82] Because the committee's findings, conclusions and recommendations concerning 13c were based on extensive hearings, including testimony of various petitioners' officials, this subsequent congressional interpretation, while not controlling, is persuasive as to its construction. *N.L.R.B.* v. *Bell Aerospace Company Division of Textron, Inc.*, — U.S. —, 94 S. Ct. 1757, 1762 (1974) and *Red Lion Broadcasting Co.* v. *Federal Communications Commission*, 395 U.S. 367, 380-381 (1969) stand for the analogous rule that legislation declaring intent of the earlier statute is entitled to great or significant weight.

E. Words are construed in their ordinary and usual sense.

Lincoln said in his First Inaugural Address (March 4, 1861, VI 171):

"The intention of the lawgiver is the law."

Similar statements have been made by this court on many occasions.[83] In deciphering this intent presumably words are used in their ordinary and usual sense, with the meaning commonly attributed to them.[84] Significance and effect should be given, if possible, to every word of the statute,[85] and the maxim "nonscitur a sociis' applied unless clearly inappropriate.[86] Plain words of the statute should control.[87] No clause, sentence or word is regarded as superfluous,

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[83] *Rathburn* v. *U. S.*, 355 U.S. 107, 109 (1957), reh. den. 355 U.S. 925 (1958).

[84] *Levy's Lessee* v. *McCartee*, 31 U.S. 102, 110 (1832); *Maillard* v. *Lawrence*, 57 U.S. 251, 260-261 (1853); *Malat* v. *Riddell*, 383 U.S. 569, 571 (1966); *Banks* v. *Chicago Grain Trimmers Assn.*, 390 U.S. 459, 465 (1968), reh. den. 391 U.S. 929 (1968).

[85] *Barnes* v. *The Railroads*, 84 U.S. 294, 302 (1872) ("The statute speaks its own construction"); *D. Ginsberg & Sons* v. *Popkin*, 285 U.S. 204, 208 (1932).

[86] *Jarecki* v. *G. D. Searle & Co.*, 367 U.S. 303, 307 (1961) (The word gathers meaning from the words around it.); *Neal* v. *Clark*, 95 U.S. 704 (1877); *First Nat. Bank & Trust Co.* v. *Beach*, 301 U.S. 435, 440-1 (1937).

Broom's Legal Maxims 450 states: "It is a rule laid down by Lord Bacon that copulatio verborum indicat acceptationem in eodem sensu—the coupling of words together shows that they are to be understood in the same sense. And where the meaning of any particular word is doubtful or obscure . . . the intention of the party who has made use of it may frequently be ascertained and carried into effect by looking at the adjoining words."

[87] *Gemsco, Inc.* v. *Walling*, 324 U.S. 244, 256 (1945).

void, or insignificant in the absence of a strong indication to the contrary.[88]

Applying these axiomatic rules to a statute as unmistakable and sharply chiseled as this leaves no doubt.

F. The word "use" and especially the words "for their own use" refer to consumption by the hospital—not for resale to others.

The noun "use", and particularly when used in conjunction with the word "own" connotes consumption (as the Court of Appeals has said)[89] by the person using it. It does not mean resale in its usual context. While the word has many secondary meanings, consumption by the user is its usual meaning. As stated by Chief Justice White (*Billings* v. *U. S.*, 32 U.S. 261, 281 [1913]):

> "The word 'use", as there employed, means more than the mere privilege of using which the owner enjoys, and relates to its primary signification, as defined by Webster: 'The act of employing anything or of applying it to one's service; the state of being so employed or applied.'"

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[88] *Washington Market Co.* v. *Hoffman*, 101 U.S. 112, 115-6 (1879).

[89] It has long been recognized that there is a clear distinction between use and resale. Wyclif (Neh. X 31) [1388] noted:

> "The puplis . . . that bryngen in thingis set to sale, and alle thingis to vss." (*XI Oxford Eng. Dicitonary* 468).

It was defined as (*Bridgeport Mach. Co.* v. *McKnab*, 136 Kan. 781, 18 P.2d 186, 187): "to make use of; to employ; to exhaust; to leave no capacity of force or use in."

Illustrations are:

> "to use a telephone; to use a saw and other tools; to use one's eyes; to use coal or eggs in cooking. (What is used often has been consumed: a used automobile; all the butter has been used." (*Random House Dictionary*, Unabr. 1966)

> "employment or usage resulting in, or such as to cause, impairment, wear, etc." (*XI Oxford English Dictionary* 469, [1961]).

> "employment causing wear; need to use (with for); manner of using; power of using (e.g., tongue, limb)." (Chambers, *20th Century Dictionary*, [1973]).

> "to consume, expend, or exhaust by use (often with up); as he has used up all his energy to smoke or chew tobacco." (*Webster's New 20th Century Dictionary*, Unabr. 2012 [1964]).

> "to expend the whole of, consume, often with up." (*Funk & Wagnalls Ency. College Dictionary*, [1968]).

Nicholson's classic (*Practical Builder* [1823]) avers that (420):

> "Plate-glass is the most beautiful glass made use of."[90]

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[90] It was held that a shoe repairer does not have "use" of leather soles and rubber heels which he placed on customers' shoes as contemplated by the taxing Statute. The rule was otherwise for hammers, awls, sewing machines and lasts which he "used" in making the repairs. *Revzan* v. *Nudelman*, 370 Ill. 180, 18 N.E.2d 219, 222.

A dentist who places a denture in the mouth of a patient was held not to "use" the denture. *Berry-Kofron Dental Laboratory Co.* v. *Smith*, 345 Mo. 922, 138 S.W.2d 452, 455.

The 1921 Act 11 and 12 Geo. V c 21, § 4 states: "A per-

The words "used" and "consumed" in a statute giving a lien to the furnisher of material, machinery, fuel or lumber used or consumed on public improvements were held to be synonymous, as the word "used" meant "used up." *Osgood Co.* v. *Peterson Const. Co.*, 231 Wis. 541, 286 N.W. 54, 57 (1939).

Under the Use Tax laws the tax is not imposed if the article is one which will be resold.[91] Under the explicit terms of the use tax in several states, use is equated with consumption.[92]

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son registered . . . shall be entitled to take and use the description of dentist or dental practitioner."

It was held that one who re-recorded a record onto another record and then sold the re-recording was not using the record unless he played it. *Liberty US, Inc.* v. *Eastern Tape Corp.*, 11 N.C. App. 20, 180 S.E.2d 414, 418.

[91] *P. H. Mallen Co.* v. *Department of Finance*, 372 Ill. 598, 25 N.E.2d 43, 44 (1939); *G. S. Lyon & Sons Lumber & Mfg. Co.* v. *Department of Revenue*, 23 Ill. 2d 180, 177 N.E.2d 316, 318-319 (1961); *Dain Mfg. Co. of Iowa* v. *Iowa State Tax Commission*, 237 Iowa 531, 22 N.W.2d 786, 789 (1946); *Granite City Steel Co.* v. *Department of Revenue*, 30 Ill. 2d 552, 198 N.E.2d 507, 512 (1964); *Douglas Aircraft Co., Inc.* v. *Johnson*, 13 Cal. 2d 545, 557, 90 P.2d 572, 576 (1939); *Hawley* v. *Johnson*, 58 Cal. App. 2d 232, 136 P.2d 638, 641 (1943); *Hervey* v. *Southern Wooden Box, Inc.*, 253 Ark. 290, 486 S.W.2d 65, 68 (1972); *Herman M. Brown Co.* v. *Johnson*, 248 Iowa 1143, 82 N.W.2d 134, 143-4, supp. opin. 248 Iowa 1158, 84 N.W.2d 44 (1957).

[92] The State Tax Guide of Commerce Clearing House, Chapter 60, notes that the following states provide that the use tax "is imposed on the storage, *use or other consumption* . . .": California, Maine, Nebraska, Nevada, Ohio, Oklahoma, Rhode Island, Utah, Wisconsin and Wyoming.

In the following states there is an express exemption from the use tax for articles which are to be resold: Indiana, Louisiana, Minnesota, Missouri, New York, Oklahoma, Pennsylvania, Texas, Utah, Vermont, West Virginia.

In many states the terms use and consumption seem to be virtually interchangeable (i.e., the use tax is imposed on the "storage, use or consumption"): Alabama, Arkansas, Arizona, Colorado, District of Columbia, Kansas, Maryland, Massachusetts, Michigan, Mississippi, New Jersey, North

In 1878 the William Astor family spent the summer touring Europe, where they acquired a number of clothes. Some they wore in Europe. Others they packed in trunks for use during the approaching "season". Their homecoming was dampened by the New York customs inspector, who levied a $1880 customs duty. An exemption was provided for (Rev. Statutes [2d ed] 489 § 2505):

> "Wearing apparel in actual use and other personal effects (not merchandise) . . . of persons arriving in the United States. But this exemption shall not be construed to include machinery, or other articles imported for use in any manufacturing establishment, or for sale."

It was held that the exemption applied even though some of the clothes had not been actually worn, if they were (*Astor* v. *Merritt*, 111 U.S. 202, 212 [1884]):

> ". . . brought with him as a passenger, and intended for the use or wear of himself or his family who accompanied him as passengers, and not for sale, or purchased or imported for other persons, or to be given away . . ."

G. Supplies normally connote things intended for use by the person supplied and not for a subsequent resale.

Similarly, the word "supplies" does not normally mean resale.

Dakota, South Carolina, South Dakota, Virginia.

In the state of Washington the use tax is levied "for the privilege of using within the state, as a consumer, tangible personal property. . . ."

In many other states there is no use tax.

A supply wagon was never the same as the vendor's cart. Supply in a military sense includes (Random House Dictionary of the English Language, Unab. [1966]):

> "all items necessary for the equipment, maintenance, and operation of a military command, including food, clothing, arms, ammunition, fuel, materials and machinery."

A more general definition of supply is (2 Britannica World Language Dictionary, 1261 [1959]):

> "to furnish with what is needed; to supply an army with ammunition."

The case at bar deals with drugs. However, the language of 13c is "supplies", not drugs. Necessarily the same question would arise with respect to food, etc.

Would petitioners seriously contend that if a hospital decided to sell milk, bread or whatever on a regular basis to its employees, physicians or the general public indiscriminately, or open a retail store downtown in competition with A & P, it should be permitted to buy such products from the farmers at discrimintary prices on the pretext they were "their supplies for their own use"?

H. 13c does not apply to purchases for subsequent resale.

In addition to "use" and "supplies", Congress made its intent manifest by using the word "their" twice, and further stressed the point by inserting

"own" ("their supplies for their own use"). Petitioners propose to strike all four words.

There is only one possible point of reference for the words "their" and "own"—i.e., the hospital. Not drop ins, staff doctors or employees who take the drugs home for their personal use of themselves or their family or friends. Rather, as Judge Merrill has said (510 F.2d 486, 489):

> "The purpose for which these are purchased—the use to which they are put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer."

The 13c exemption is intended to be used to provide hospital care for needy sick. One consuming drugs at home is not receiving hospital care.

When the bill which became 13c was reported to Congress, both Senate and House committees quoted an identical letter from John Hayes, President of the Hospital Bureau of Standards and Supplies (Pet's Br. 38-39, 41). Mr. Hayes asked for the 13c exemption on the grounds the hospitals needed it to provide "foodstuffs and supplies for the care of the needy sick" and because "(t)he needy sick must be cared for . . ." Otherwise, he insisted, "many hospitals may have to close their doors".

Mr. Hayes was referring to hospital care.

As used by Mr. Hayes "care" is a noun meaning treatment in the hospital. Care in this context nor-

mally connotes "charge; protection; custody; as, he was under the care of a physician" *(Webster's New 20th Century Dictionary*, Unabr., 2d ed. [1965]).

What hospital care is being extended to a nonhospitalized drop-in nonpatient, a mail order customer, or an employee or physician or their families who consume the drug, food, etc., at their own homes, and some of whom may not be ill at all?[93]

II. Other Legal Authorities Are in Accord With the Ninth Circuit

Petitioners cite only two cases which bear directly on 13c.

The first was discussed in the opinion below as follows (510 F.2d 486, 490):

> "In this respect our case is similar to Students Book Co. v. Washington Law Book Co., 98 US App 49, 232 F 2d 49, 50-51 n 5 (1955), cert den 350 US 988 (1956), where the 13c issue was disposed of in a footnote. The plaintiff, a retailer seller of law books, complained of the defendant's sales at lower prices of books to campus bookstores at law schools. The distinction drawn by the court was similar to the one we draw here—between sales of books to universities for their own use, i.e., for their libraries, and sales to university-connected book stores for resale to students."

[93] The Hospital Bureau of Standards and Supplies which proposed 13c has since changed its name to Hospital Bureau. It was founded in 1910 as a *(Encyclopedia of Associations)*:

> ". . . national group purchasing organization for cooperative buying of hospital supplies and equipment."

It was not organized as a vehicle to sanction general commercial sales by hospitals to nonhospitalized persons.

Judge Bazelon, who wrote the *Student Book* opinion, also dissented in part. However, his dissent dealt with an issue irrelevant to this case and 13c—i.e., whether the jury should have been given an expanded definition of consignment. In making the statement quoted above he spoke for the entire court.

The second, *Logan Lanes, Inc.* v. *Brunswick*, 378 F.2d 212 (9th Cir.), cert. den. 389 U.S. 898 (1967), is from the same circuit which decided this case. In *Logan Lanes*, Utah State University purchased Brunswick bowling lanes and related equipment for permanent installation in its Student Union Building. After it was installed it was used by students of the University's physical education classes along with faculty and staff. On occasions some members of the public also used the lanes.[94] In our case the court below distinguished *Logan Lanes* as follows (510 F.2d 486, 489):

> "Logan Lanes, Inc. v. Brunswick Corp., supra, does not require the contrary result. There the alleged discriminatory pricing was for bowling alley equipment sold to a state university. The lanes had been acquired for use in connection with the university's physical education program and for recreation use of faculty, staff and students and were operated for those purposes. They were not, however, closed to the

[94] According to an affidavit submitted by Brunswick 124,415 lines were bowled from 1964-1966 by students, faculty, staff and guests, while 2,934 were bowled by others. According to affidavits submited by Logan Lanes, no effort was made to determine whether prospective customers were associated with the University.

general public and some public use (the extent was disputed) was made of them. We held:

'The primary purpose of the purchases established beyond dispute, was to fulfill the needs of the University in providing bowling facilities for its students, faculty and staff. This being the case, any additional use of the bowling facilities by the general public for a fee, even if such use is substantial, would not establish that the purchases were not made for the use of the University.'

"378 F.2d at 16. The university's public use was indeed in competition with other local alleys, and it may be questioned whether the university should not, in all fairness, have been compelled to choose between the public use and the favorable exemption. But that is not what the statute requires. It requires only that the 'supplies' be acquired by the university for its own use. It does not say that once acquired and put to that use they cannot then be used for any other purpose.

"Our case does not involve the acquisition of plant equipment. It involves acquisition of stores of supplies. Plant equipment acquired for a university's own use cannot be segregated from that acquired for use by others, since the same equipment serves both uses. In the case of stores of supplies acquired for consumption the situation is otherwise. Supplies that are resold can readily be segregated from those devoted to a hospital's own use."

We submit, this logic cannot be faulted.

The language of 13c is "purchases of their supplies for their own use." Necessarily the situation must be judged by that at acquisition—i.e., the purchase. When acquired—and at all times thereafter—Utah State fully intended to use the lanes itself, and did so. The fact that later it did not stop a few outsiders from using the lanes too in no way alters the original intent. The lanes were not divisible.

In *Logan Lanes* the court defined the word supplies as (1c 216):

". . . anything required to meet the institution's need . . ."

The primary definition of need is (Webster's 7th New Collegiate Dictionary 565 (1969)):

"A condition requiring supply or relief; (syn) need implies urgency and may suggest distress."

Under what logic could drugs, foods, etc., which a hospital buys for resale to nonhospitalized persons for their private use at locations remote from the hospital, be regarded as items needed by the hospital for the hospital's own use?

Other distinctions between this case and *Logan Lanes* are capsulated on pages A19-24 of Respondent's Brief in Opposition to Certiorari. There are others.

III. Congressional Purpose Will Be Frustrated if Hospitals Are Permitted to Obtain Drugs at Discriminatory Prices for Nonhospital Uses

The hospital trade association, which persuaded Congress to pass 13c in 1938, did so by convincing Congress the exemption was needed by nonprofit hospitals "because of the charitable nature of their work" "so that they might be able to provide" foodstuffs and supplies for the care of the needy sick because, the association argued,[95]

> "The needy sick must be cared for and such a development would throw an almost impossible additional burden on the Federal, State, and municipal institutions."

Subsequent to the passage of 13c, the charity extended by hospitals has been largely eliminated. More and more these charges are being absorbed by Medicare, Medicaid, OEO, medical welfare (state, federal and local) and various insurance programs, not to mention various federal and state grants for construction and other purposes.[96] As stated in one of the cases cited most conspicuously by petitioners and AHA *(Eastern Kentucky Welfare Rights Organization* v. *Simon* [D.C. Cir. 1972] 506 F.2d 1278, 1288, cert. granted May 19, 1975):

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[95] Pet. Br. 39.

[96] Hearings, supra, 55, 287. (The government will soon be paying approximately one-half its citizens' pharmaceutical bills under Medicare, state, local programs, etc.); R. 473; Desrosiers 18; Fawkes (2nd) 21; Ferrell 14; Hastings 11; Hollowell 9-10; Johnston 43; Matlick 21, 23; Slick 9; Sperry 21; Knowles, The Hospital, *Scientific American* (Sept. 1972) 128, 135.

> "The institution of Medicare and Medicaid in the last decade combined with the rapid growth of medical and hospital insurance has greatly reduced the number of poor people requiring free or below cost hospital services. Much of that decrease has been realized since the promulgation of Revenue Ruling 56-185. Moreover, increasingly counties and other political subdivisions are providing nonemergency hospitalization and medical care for those unable to pay. Thus, it appears that the rationale upon which the limited definition of 'charitable' was predicated has largely disappeared."[97]

Quite a few of the hospitals,[98] including at least one in Portland, no longer accept indigent patients,[99] while more than once the state has been overcharged for welfare patients.[100] Two Portland hospitals will

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[97] This court has noted the same trend in *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250, 265 (1974).

Professor William Thomas stated:

> "The image of a voluntary institution as a charitable organization, financing its care of patients to a substantial degree through philanthropy . . . is largely anachronistic." *Hearings on Conditions and Problems of the Nation's Nursing Homes, Subcommittee on Long Term Care*, Spec. Committee on Aging, U.S. Senate, 89th Cong., 1st Sess., Pt. 2 (February 15, 1965) p. 559.

A survey of 2558 emergency room patients at Barnes Hospital in St. Louis reveals that only 9.1% were not covered by Medicare, Medicaid, Blue Cross, Blue Shield, or some other type of coverage. Perkoff and Anderson, Relationship between Demographic Characteristics, Patient's Chief Complaint, and Medical Care Destination in an Emergency Room, *VIII Medical Care* (July-Aug. 1970) 309, 319.

[98] *Memorial Hospital* v. *Maricopa County*, supra; *Eastern Kentucky Welfare* v. *Simon*, supra.

[99] R. 688-9 (except emergencies); cf. R. 809.

[100] R. 550, 810, 811, 939.

not accept drug prescriptions from welfare patients.[101]

The extent to which hospitals have moved away from the concept of charity for the "needy sick" is seen in one of the articles cited by AHA. It appears in *Hospitals* magazine for September, 1942 (four years after 13c was passed). It states (Martin, Control of Out-Patient Services and Charges, *Hospitals*, 85, 86):

> "The needy sick we shall always have, and they are definitely a charge and responsibility of the government. Their care and treatment both as out-patients and in-patients should be borne to a large degree by local, state or federal payments."

Is it not incongruous for hospitals, having obtained the passage of 13c assertely to provide "care" for the "needy sick" but which have largely forsaken charity, to now assert that 13c should be distended so that they can provide drugs at bargain prices to staff doctors, employees, and other nonhospitalized persons while often charging the full rate to in-patients, and in the process obliterate the neighborhood taxpaying pharmacies?

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[101] Shu[illegible] 19; McConnell 34.

Attached to the back of the brief is a chart showing sales at 14 Portland hospitals, which petitioners accept as accurate. It reflects drug sales by the hospitals for the period of $32,792,997, and net profits of $10,155,165. The average net profit on drug sales was 38.68% for the 13 hospitals for which profit data was available. Two hospitals reported annual net income from overall operations in excess of $1 million (R. 557).

IV. History

Few, if any, hospital drug sales to nonhospitalized patients were made at the time of the passage of 13c in 1938. Normally statutes are construed with reference to the circumstances which existed at time of passage. Statutes are not "modified" except by the enacting body.

Petitioners placed nothing in the record as to hospital drug distribution practices in 1938, the year 13c was passed.

Appendices VIII, IX and X at A43 et. seq. of the *Brief for Respondent in Opposition* establish that hospital drug sales for uses outside the hospital are a post-1938 development throughout the Northwest.

Petitioners' brief counters with a few scattered literary references to some early day outpatient clinics in other locations. These are, of course, far cries from the 1,000,000 plus prescription sales to non-hospitalized persons at Portland's Kaiser Hospital, etc.

The situation in the Northwest is not atypical of the US generally. In 1932 no more than 1500 of the 7000 U.S. hospitals employed full-time pharmacists (A45-46). As late as 1964 less than one-half had pharmacists who could fill prescriptions (A46).

Petitioners assert that 13c should be enlarged because today hospitals make many more sales to non-patients for outside use than they did in 1938.

This Court has repeatedly rejected statutory expansion by judicial fiat. *Gulf Oil Corp.* v. *Copp Paving Co.*, — U.S. —, 95 S.Ct. 392, 402 (1974).

Fortnightly Corporation v. United Artists Television, Inc., 392 U.S. 390, 401-402 (1968) held:

> "We have been invited by the Solicitor General in an *amicus curiae* brief to render a compromise decision in this case that would, it is said, accommodate various competing considerations of copyright, communications, and antitrust policy. We decline the invitation. That job is for Congress. *We take the Copyright Act of 1909 as we find it.* With due regard to changing technology, we hold that petitioner did not under that law 'perform' the respondent's copyrighted works." (fns. omitted) (Emphasis added).

Since at least 1879 this Court has held that statutes are construed with reference to the circumstances existing at the time of passage.[102]

Mobile & Ohio RR Company v. *Tennessee*, 153 U.S. 486, 502 (1894) held:

> "Legislative contracts, especially, should be read in the light of the public policy entertained, and the purposes sought to be accomplished at the time they were made, rather than at a later period when different ideas and theories may prevail. * * *"[103]

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[102] *Platt* v. *Union Pacific RR Co.*, 99 U.S. 48, 60 (1879).

[103] Other decisions holding that statutes are construed with reference to the circumstances existing at time of passage include: *United States* v. *Smith*, 197 U.S. 386 (1905); *United States* v. *Wise*, 370 U.S. 405, 411 (1962); *Civil Aeronautics Board* v. *Delta Air Lines, Inc.*, 367 U.S. 316, 323 (1961); *United States* v. *Champlin Rfg. Co.*, 341 U.S. 290, 297 (1951); *United States* v. *Rothberg*, 480 F.2d 534, 535 (2d Cir. 1973), cert. den. 414 U.S. 856; *Husted* v. *Consumers Power Co.*, 376 Mich. 41, 54, 135 N.W.2d 370, 375-376 (1965).

The Court has held that while old laws apply to changed conditions, a changed condition does not repeal the law.

V. Take-Home Drugs Are Not Covered by the 13c Exemption Since Not Intended for the Hospital's Own Use

There is nothing in the record to support petitioners' claim that many discharged bed patients are physically unable to secure drugs from commercial pharmacies after discharge (Pet. Br. 14, 26).

Petitioners' protests that the hospitals are protecting the patient are belied by two uncontradicted depositions (Carlson, Pye) that the respective hospitals compelled purchase of "take-home" drugs despite the expressed wishes of the captive purchasers to obtain the prescriptions from their drug stores.

Critically ill patients are seldom discharged from hospitals.

Persons who require care after hospital discharge normally are:

(1) transferred to convalescent or nursing homes; or

(2) receive care from friends and members of their families or from visiting nurses.

There is nothing in the record to support petitioners' alarm that discharged patients cannot rely on the capacity or willingness of neighborhood pharmacies (Pet. Br. 25).

Most patients are discharged from hospitals during daylight hours while retail pharmacies remain open as late as 10:00 p.m.[104]

Respondent's drug store assignors and other neighborhood pharmacies provide prescription delivery service (Meek's Rexall Powell Pharmacy), mail order service (Mt. Scott Pharmacy) and seven-day-a-week, 24-hour after-hours emergency service.[105]

An ambulatory patient (Pet. Br. 25) is, by definition, physically mobile and thus capable of securing his prescription needs in the community; he is not dependent on the hospital for his drug needs.

"Take-home" drugs for departing patients are frequently for the profit of the hospitals, and only nominally for the convenience of the patient.

VI. Employee and Physician Drug Purchases for Their Personal or Family Use at Home Are Not Supplies Used by the Hospital

The Court of Appeals ruling does not interfere with the privilege of hospital employees and physicians to obtain drugs at huge discounts from the much higher prices the hospitals charge unprivileged and captive patients.

The hospitals can continue to sell drugs to their employees and staff at any price as a "fringe" bene-

[104] Matlick 20.
[105] R. 646; Portland Telephone directory 851-2 (1975).

fit. Collective bargaining agreements are not affected.

Petitioners confuse the discount purchase "privilege" which hospitals have chosen to give their employees and staff physicians with the exemption granted the hospitals as institutions.

The exemption belongs to the hospital, and then only for purchase of "their supplies for their own use," not the employees of physicians.

Hospital employees and physicians are ambulatory. They could, if they wished, buy their drugs in the community.

The opinion does not take away "the privilege of purchasing drugs at the hospital pharmacy" (Pet. Br. 29).

All the opinion means as to the hospitals is that the hospitals will pay the same regular trade price as drug stores on drugs resold by the hospitals to employees and physicians, who are not patients themselves.

VII. The Standard Enunciated by the Court of Appeals Is Logical and in Keeping With the Express Language of 13c. It Can Also Be Administered With Ease

Petitioners and AHA importune that the 13c exemption should be distorted to encompass virtually every hospital purchase because the alternative would require segregated drugkeeping or bookkeeping.

Aside from the obvious irrelevancy of this tack, the premise is not correct either, because:

(1) Petitioners can satisfy the law by simply reducing their prices to drug stores to a comparable level charged hospitals for items sold to hospitals not intended for hospital use. If so, there would be no change in hospital prices and no need for segregation.

(2) All drugs sold for extrahospital use now are assigned a prescription number under applicable law, while those used intrahospital are not numbered and are called hospital orders.[106] Hospitals can determine the numbers and amounts of drugs which leave the hospital by checking their prescription records.

(3) In many hospitals today, the outpatient pharmacy is distinct and apart from the inpatient pharmacy.[107] In such cases there should be no problem whatever.

(4) Certain drugs—notably narcotics—are normally separated from other drugs now.[108] There is no indication that this is an onerous task.

(5) Petitioners maintain large numbers of detailmen, who frequent hospitals and attempt to keep

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[106] R. 716; see ftn. 44; Fawkes (2nd) 15; Zeasas 8-9.

[107] 31% of all short-term hospitals having 500 or more beds have an outpatient pharmacy, which is entirely separate from the regular hospital pharmacy. (Francke, Latiolais, Francke & Ho, *Mirror to Hospital Pharmacy*, 118 [1964]).

[108] Clarke, Medications for Outpatients; Operating a Successful Dispensary, *20 Hospitals* (October 1946) 60, 61.

close tabs on the drug needs of their hospital customers by checking stocks, etc., [109] and submit periodic reports to their employers.[110] It should be relatively easy to approximate the percentage not required for hospital needs.

(6) Petitioners have appealed from only a part of the 9th Circuit ruling. Thus, some bookkeeping segregation will be needed anyway.

(7) At the House Subcommittee hearing, the same questioin was presented to Earl Kintner, former FTC Chairman. Mr. Kintner testified that a similar separation is made (Hearings, supra 1c 20-21):

> "In many other areas of America, where a buyer purchases in more than one capacity, say as a retailer and as a wholesaler, that proportion of his business which is wholesale usually receives a better price than that portion of his business which is retail. This is a common way of complying with the Robinson-Patman Act, and it is understood by American businessmen generally."
>
> "MR. POTVIN: 'In fact, sir, are there not many industries such as the automotive parts industry, in which the credit-memo debit-memo manner of handling the split function has been a part of the landscape for several decades?"
>
> "MR. KINTNER: 'You are quite correct, Mr. Counsel. This is to my knowledge technically

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[109] Bremner 23; Coffee 38; Connerty 43; DeLong 63; Eldien 12; Haas 12; Kobelin 47; McClintic 89; Mason 89; Winther 10.

[110] Mason 44; Metz 115.

true in the automotive parts industry and in the gasoline refining business."

As to petitioners' assertion of alleged difficulty in determining the aliquot part used for hospital uses from that which is not, Mr. Kintner described such argument as (Hearings, supra 1c 27):

> "... an old chestnut. The businessman says, 'Well, I can't send my accountant in to audit his books.' Well, of course, he can't and he shouldn't. And he needn't do an extreme amount of policing that would absolutely, beyond peradventure, indicate how much of the business is at one function and how much at another function.
>
> "But businessmen do not operate in a vacuum. They have a certain amount of information available to them from trade sources. They are able to estimate, with a fair degree of accuracy, how much of a particular business is done at one function and how much is done at another, without going into the intimate details of a business operation as an internal revenue agent might. Minimally, they could rely upon what the buyer represents to them, and only question if they have good reason to question."

(7) For years quite a number of drug manufacturers, as a precondition to obtaining a preferential price, have required assurances from hospitals that the drugs be used exclusively for the hospitals' own use.[111] Petitioner Eli Lilly, for example, makes its

[111] R. 530 (A. H. Robins); Fawkes Ex. 9 (Carter-Wallace); R. 656. (The Sandoz agreement requires the hospital on preferentially priced drugs to dispense such drugs "exclusively within the confines of the purchasing institution.")

hospital customers sign an agreement that reads (Fawkes Ex. 8):

> "This account represents that it is a non-profit organization (tax-exempt hospital or tax-supported institution) and that purchases made under this agreement are for its *own use within the institution and are not for resale.*" (Underlining supplied).

Some petitioners print labels on products sold to hospitals on favored terms, such as "Hospital Use Only" or "This Package For In-Hospital Use Only".[112] Are such labels only empty gestures? Are they not acknowledging, by doing so, the distinction between a hospital use, and a use by a private individual at some location other than the hospital though the drug, for a time, may have rested on the shelf of some hospital pharmacy?

Many insurance policies and Medicare pay for drugs only where used in the hospital, and not elsewhere.[113] A bookkeeping bifurcation of hospital from non-hospital drugs occurs now to this extent.

VIII. Neighborhood Drug Store Pharmacies Should Be Preserved

While not overtly espousing the point, the unspoken premise for many of petitioners' arguments

[113] Department of Health, Education and Welfare, *"A Report to the President"*, (February 1967), 36.
Your Medicare Handbook, D.H.E.W. Publication No. (SSA) 73-10050, 9, 11, 20.

[112] R. 539, 872; See H.R. No. 1983, 90th Cong., 2d Sess. 58 (1968).

is that hospital pharmacies and pharmacists are inherently superior to their counterparts in drug stores.

The argument is irrelevant. It is also fallacious. Besides, we submit, if an economic judgment is to be made, it should be made by consumers under conditions of free and open competition. Neutral studies have also shown that approximately one in six or seven of all medications dispensed in hospitals is wrong.[114]

This issue has no real relationship, in our view, to the issue before the Court. At the same time we do not wish the Court to conclude that we agree with petitioners' contentions. For that reason we have attached in Appendix D, a discussion of some of the reasons showing that there are many values worth preserving in drug store pharmacies and that they are superior to hospital pharmacies in many respects.

IX. Destination of Hospital Profits Irrelevant

Petitioners' repeated reference to the fact that the hospitals' huge drug profits are used to support other activities within the hospital or plant expansioin (Pet. Br. 8-9) is irrelevant. The only live issue

[114] Ibid. fn. 41 at 262; Tester, William W., A Report of the Iowa Drug Distribution System, *Drug Intelligence*, 11 Nov. 1968, pp. 305-309; Stewart & Cluff, A Review of Medication Errors and Compliance in Ambulant Patients, *13 Clinical Pharmacology and Therapeutics* (July-August 1972) 463, 465; Barker & McConnell, How to Detect Medication Errors, *99 Modern Hospitals*, 95-106 (1962).

is whether the purchase of supplies for resale to nonhospitalized persons for use outside the hospital can fairly be regarded as hospital "supplies for their own use".

In any event the source of the profits, not the final destination of the profits, has been the controlling factor for years in the tax field in determining whether some activity is tax exempt. The fact that the profits generated from an unrelated business are used finally for the support or expansion of a tax-exempt hospital does not mean that the profits are tax exempt.[115] It is the use of the property and not the use of the proceeds derived therefrom which is determinative of the question of tax exemption. If this were not the law then virtually every druggist who makes contributions to his church could also claim tax exempt status too.

The Tax Reform Act of 1969, P.L. 91-172, inter alia, embodies the congressional intent that if tax-exempt organizations such as hospitals engage in commercial business in competition with taxpaying business, the tax-exempt organizations shall pay taxes on their unrelated business income. Thus, 26

[115] *Louise W. & Maud Hill Family Foundation* v. *United States* (Minn. 1972) 347 F. Supp. 1225, 1227; (see also *University Hill Foundation v. C. I. R.* (9th Cir 1971) 446 F.2d 701, 706, cert. den. 405 U.S. 965; *Bear Gulch Water Co. v. C.I.R.* (9th Cir. 1941) 116 F.2d 975, 977; *Umatilla County* v. *Sturtevant*, 9 Or. App. 55, 58, 495 P.2d 287, 288 (1972); *Sutter Hospital of Sacramento v. City of Sacramento*, 39 Cal. 2d 33, 244 P.2d 390, 394-395 (1952); *Cleveland Osteopathic Hospital v. Zangerle*, 153 Ohio St. 222, 91 N.E.2d 261, 264 (1950); *Oklahoma Tax Commission v. Sisters of Sorrowful Mother*, 186 Ok. 339, 97 P.2d 888, 893 (1939).

C.F.R. § 1.513-1, Definition of Unrelated Trade or Business, states in part:

> "* * * the regular sale of pharmaceutical supplies to the general public by a hospital pharmacy does not lose identity as trade or business merely because the pharmacy also furnishes supplies to the hospital and patients of the hospital in accordance with its exempt purposes . . ."

Two of the Portland hospitals have paid income tax on their drug generated nonpatient sales for some time.[116]

X. De minimis argument is not applicable here

Although petitioners at times have indicated they are not relying on the de minimis argument,[117] nevertheless it seems to be the unspoken premise for many of petitioners' arguments here.

Under no conceivable circumstance is it applicable here where the extent of hospital resales for nonhospital uses exceeded one million.[118]

Such defense is generally rejected anyway.[119]

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[116] R. 447.

[117] See p. 18, supra.

[118] See p. 19, supra.

[119] *Case-Swayne Co., Inc. v. Sunkist Growers*, 389 U.S. 384 (1967); *Maryland v. Wirtz*, 392 U.S. 183, 192-193 (1968); *Founding Church of Scientology v. United States*, 412 F.2d 1197, 1202 (Ct. Cl. 1969), cert. den. 397 U.S. 1009; *Fields v. United States*, 228 F.2d 544, 546-547 (4th Cir. 1955), cert. den. 350 U.S. 982; *Northern v. Nelson*, 448 F.2d 1266 (9th Cir. 1971); *National Labor Relations Board v. Suburban Lumber Co.*, 121 F.2d 829, 832 (3rd Cir. 1941); *Community Currency Exchange v. NLRB*, 471 F.2d 39, 42 (7th Cir. 1972).

CONCLUSION

The Court of Appeals Standard Is Legal and Practical

The Court of Appeals opinion creates a workable and fair standard for hospitals and their suppliers.

It upholds the express statutory purpose of the Robinson-Patman Act to protect competition.[120]

The 14 hospitals that resell drugs purchased at discount prices to persons for off-premises consumption are in direct competition with drug stores and are, necessarily, not using the drugs for their own use as the statute requires.

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[120] The Clayton Act had the support of all three parties when it was passed. The Robinson-Patman Act was passed in 1936 to plug certain loopholes which Congress felt existed in the Clayton and Sherman Acts (40 Cal. L.R. 526, 535 [1951]); H.R. No. 2287, 74th Cong. 2d Sess., p 6, (1936). Only 16 votes were recorded in opposition in the House of Representatives and none in the Senate. (Patman, *Complete Guide to the Robinson-Patman Act*, 10).

The House Committee on the Judiciary in 1956 made the following report:

> "Price discriminations favoring preferred buyers presented danger to the competitive enterprise system which is inconsistent with the policy of the price discrimination statute. Firms can abuse their superior market position and engage in discriminatory practices and eliminate small suppliers and small retailers from the competitive scene." (H. Rep. No. 2202, 84th Cong. 2d Sess., 1956).

The preceding year it was stated (Hearing on Price Discrimination Before the House Select Committee on Small Business, 84th Cong., 1st Sess., 1 at 631 [1955]):

> "The belief that price discrimination tends to be objectionable runs as a thread through all the history of economic thought on the effects of competition."

It was feared that if the Act is not enforced, then the only remaining alternative was direct government control and price fixing, which it was hoped could be avoided. (15 U. of Miami L.R. 225, 234 [1961]).

These 14 hospitals can continue to sell drugs to whomever they please, provided only that they cannot obtain drugs at discriminatory prices under the pretext that they are for the hospital's own use, when they are not to be so used.

Even petitioners and the district court recognize that the 13c exemption is limited.[121]

Petitioners further recognize the narrow scope of the exemption.

They do so by not appealing the Court of Appeals ruling that take-home refills and sales to walk-in members of the public, physicians for their office use and families of employees and physicians were outside the exemption.

Whether or not the Court of Appeals is affirmed or reversed, the hospitals and their suppliers must conform to the unappealed portion of the decision.

By their lack of protest or appeal the petitioners apparently concede that (1) the unappealed portions are correct as a matter of law and (2) do not impose any hardship or unworkable standard on the hospitals and petitioners.

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"THE COURT: I take it you'd have a different case if St. Vincents decided to acquire a chart—a fleet of fishing charter boats and supplied the dramamine for the charter boats' customers through one of its suppliers here.

"MR. CLARKE: That might be a different case, Your Honor. (Laughter.)

"I think you have approached the limit." (Tr. May 25, 1973, pp. 28-29)

There is nothing in the record or petitioners' brief to indicate why one part of the decision is unremarkable and the other creates difficulties.

Nothing in the record indicates that affirmance of the Court of Appeals will have an adverse effect on the care of persons receiving hospital, clinic or emergency treatment.

The decision does not limit the use of drugs. The physician, not the hospital, makes the decision on drug dispensing. That decision is based on therapeutic benefit, not the cost of the drug to the hospital or the patient.

Nothing in the record indicates that affirmance of the decision will have any adverse economic effect on hospitals.

Assuming (as petitioners claim), but not conceding, that only 10 per cent of hospital drug dispensing by volume is in dispute, 90 per cent of hospital drug purchases are unaffected by the decision.

Putting neighborhood pharmacies out of business, lessening competition and thus depriving the public of the ability to purchase drugs without the expense of travel to a hospital is a more serious matter than the minor impact on hospitals of complying with the law when they engage in retail trade.

The protection of competition, and therefore the public interest, is paramount under the Robinson-Patman Act.

The public interest is best served by fair, unsub-

sidized competition. Drug stores still sell more drugs than do hospitals—(though the percentages are closing rapidly).[122] Any who buy their drugs from such drug stores must necessarily pay more because the hospitals, and the doctors and employees who work there, are able to buy the same drugs at a discriminatorily lower price.

The workingman should not have to pay substantially more for drugs so that, for example, the physician may pay less.

Physicians do not need economic subsidies intended exclusively for the hospitals as institutions.

It is the consumer who pays for the practices struck down by the Court of Appeals, for as the House Small Business Committee concluded:

> "* * * Consumer interests are compromised by permitting drug price discrimination in the area, because the retailers and consumers ultimately must pay higher drug prices as a form of economic subsidy to the drug supplier for the lower prices which that drug supplier charges the institution." (Pet. Br. Opp. A6)[123]

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[122] R. 683.

[123] The State of California in 1968 passed the Crown Act (Chap. 1237, Statutes of 1968, § 14053.5, California Welfare and Institutions Code discussed at R. 122) which prohibits the charging of different prices to drug stores than to hospitals for drugs provided to Medi-Cal recipients. Medi-Cal is California's equivalent of the federal Medicare program.

Before its passage a Report of the Subcommittee on Health, Education and Welfare Services on Drug Prices, was issued by the Assembly Interim Committee on Ways and Means, California legislature, Assembly Interim Committee Report, 1965-67, Vol. 21, Number 18 (1c20):

Affirmance of the of the Court of Appeals will not hinder the nonprofit hospitals in the avowed reason for the exemption—care of the needy sick. That function — in the main — hospitals have managed since 1938 to shift to the taxpayer anyway; hence there is no need for judicial expansion of the § 13c exemption. But they cannot use the narrowly drawn exemption of 13c, which is limited to their supplies for their own use, to acquire drugs or other supplies at discriminatory prices, when they have no intent to use the same for or within the hospital.

Respectfully submitted,

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"The subcommittee recommends that the Legislature consider ways of eliminating the alleged multiple pricing practices of certain drug manufacturers, which inflates the wholesale costs of drugs to community pharmacies through which the vast majority of state pharmaceutical expenditures are channeled . . ."

"To the extent that such pharmacies are forced to pay higher prices for the products they later supply to Medi-Cal recipients, state pharmaceutical expenditures are thereby inflated."

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Supreme Court, U. S.
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MICHAEL RODAK, JR., CLERK

No. 74-1274

In the Supreme Court

of the United States

OCTOBER TERM, 1974

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

APPENDICES TO RESPONDENT'S BRIEF

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APPENDIX A

LACK OF COMPETITION IN THE DRUG INDUSTRY

Excerpts from the hearing on *Small Business Problems in the Drug Industry* by the Subcommittee on Activities of Regulatory Agencies of the Select Committee on Small Business, House of Representatives, 90th Congress, First Session (1967-8) pursuant to H. Res. 53.

References to the absence of true price competition in the pharmaceutical industry are found on the following pages: 194, 197, 205, 206, 207, 246, 294, 304, 308, 309, 313, 318, 319.

The following colloquy appears on p 194 between the committee's counsel (Potvin) and one of New York's largest wholesale druggists (Jack Mandell):

"MR. POTVIN: But in those areas where there are only full-line wholesalers, is it not a fact, sir, that price competition is regarded by most observers to be totally absent?

"MR. MANDELL: For many years it was."

Also on page 197:

"MR. POTVIN: (A)s the late Senator Kefauver so well established, price competition between manufacturers is rather less than vibrant in your industry as well; is it not?

"MR. MANDELL: Yes, I would say that sir."

Another wholesaler (Hyman Moore of New Britain, Connecticut) was asked (1c319):

"MR. POTVIN: Are you saying, sir, than that as concerns the community pharmacist, manufacturers do not engage in price competition with each other?

"MR. MOORE: Very rarely . . . I have heard stuff about incremental costs and so forth and so on, and incremental costs for selling merchandise for export. I personally think that is a lot of hogwash. I think prices are lower to hospitals, I think prices are lower for export, I think prices are lower in city and county, State governments because there is competition in those areas. I think they make a profit when they take something like prednisone and instead of $170, they go down to $4, or whatever it is, I think they are making a profit on that price. They consider it plus business. I think they are selling merchandise for whatever the traffic will bear, they are getting as much as they can for what they can. I do not see why prices should be lower for export than things brought here. I don't know that any foreigner's money is better than mine or Mr. Average Consumer's.

"I do know there is competition. I do know there are pharmaceutical industries in these countries that are quite well developed and American manufacturers have to meet them. They don't have to meet them here. Otherwise, you could not take common generic products that cost just a few pennies and keep the price at $22.60 a thousand, which has been as long as I have been in the business, which is 20 years."

At the conclusion of the hearings the Subcommittee, after considering other evidence of "possible

parallel pricing practices," concluded (A Report of Subcommittee No. 5 to the Select Committee on Small Business, House of Repr., 90th Congress, 2nd Sess. [1968] 77 [H.R. 1983]):

"There is little or no price competition in the marketing of trademarked pharmaceutical products among manufacturers.

. . .

"More vigorous action is required at the earliest possible time on the part of the Federal Trade Commission to enforce the Robinson-Patman Act and other statutes administered by it if small business drug wholesalers and retail pharmacists are to continue their important role in serving the Nation's health needs."

And that (1c 80):

"As pointed out herein above, there is an almost total absence of the usual type of price competition in the marketing of trademarked pharmaceuticals."

An article in 53 Virginia L.R. 1285-6 (1967) stated:

"As a result one might expect the prices of ethical drugs to be established by individual manufacturers largely on the basis of their cost functions, and without reference to the prices charged by competitors. Since the production and promotional costs of sellers are quite likely different, their prices should reflect this difference. However, where major producers are concerned, this is frequently not the case."

Another example of the lack of price competition in the U.S. drug industry appears in the Congressional Record, September 29, 1972, where Senator Gaylord Nelson stated:

> "The price of 100 tablets of propoxyphene, Darvon, sold by the Lilly Co. to the druggist in the United States is $7.02, but the price charged by the same company for the same product in Ireland is $1.66, and in the United Kingdom is $1.92. Bristol charges $21.84 for 100 tablets of ampicillin in the United States, but $9.31 in Ireland; Ciba charged $3 for glutethimide, Doriden, in the United States, but 92 cents in Ireland, $1.23 in New Zealand, and $1 in the United Kingdom. The Pfizer Co. charges $20.48 in the United States for oxytetracycline, Terramycin, but $4.63 in Brazil and $3.68 in New Zealand. These are only a few examples of discrimination against the American people."

See also Green, *The Monopoly Makers* 257-285 (1973); Kefauver, *In a Few Hands (Monopoly Power In America)* 8-79 (1965). Also *U.S.* v. *Parke, Davis & Company*, 362 U.S. 29 (1960) (Parke, Davis was recently absorbed by petitioner Carter-Wallace, Inc.); *William H. Rorer, Inc.* v. *Federal Trade Commission*, 374 F.2d 622 (2nd Cir. 1967); *U. S.* v. *Carter Products, Inc. and American Home Products*, 211 Fed. Supp. 144 (S.D. N.Y. 1962); *U. S.* v. *Ekco Products Company and Ekco-Glaco Company*, 1966 Trade Cases ¶ 71,764 (U.S. D.C. N.D. Cal. 1966) (both Ekco Products and Ekco-Glaco are divisions of defendant American Home Products Corporation; *U. S.* v. *Fisons Ltd., Fisons Pharmaceuticals, Ltd., Colgate-Palmolive, Armour & Co. and American Home Products Corp.*, 1972 Trade Cases ¶ 73,794 (U.S.D.C. N.D. Ill. 1972); *In re Antibiotic Antitrust Actions*, 333 F. Supp. 267 (S.D. N.Y. 1971) (defendants include Bristol-Myers and Squibb).

APPENDIX B

Next Page

APPENDIX B

ILLUSTRATIVE COMPARATIVE PRICES CHARGED HOSPITALS AND RETAIL DRUGGISTS*

Manufacturer	Drug	Reference	Quantity	Price to hospitals	Price to druggist
Abbott Laboratories	Penicillin V Potassium 125 mg	R730	100	$ 1.95	$ 5.37
	Hydrochloro-thiazide 50 mg	R730	1000	29.50	41.18
	Erythromycin ethyl succinate 200 mg	R730	50	8.55	9.00
American Home Products	Omnipen 250 mg 8-55-1 5 cc	R731	80 ml bottles	.79	2.26
	Omnipen 8-315-6 500 mg vial	R731	10	2.50	19.00
	Omnipen 8-315-9 1000 mg vial	R731	10	4.50	26.00
American Home Products (Cont.)	Equanil 1R481 400 mg	R731	500 1000	12.36 24.50	29.50 58.00
	Bicillin LA 6000MU tubex pkg of 10	R731-732	1-9 10-99	8.75 8.00	13.46 12.08
	Bicillin LA 1200MU tubex pkg of 10	R731-732	1-9 10-99	15.00 14.00	23.24 20.92
Bristol-Myers Company	Erythromycin 250 mg base Bristamycin	R731	100	7.24	9.48
	Amphycillin 250 mg	HR 1983 90th Cg. 12	100	11.96	27.25
Wm. H. Rorer, Inc.	Ananase	Connerty 38	50	5.76	6.12
Squibb	Neomycin sulphate tablets	HR 1983 90th Cg. 12	100	5.20	20.54
	Principen-N #9716		500	17.40	60.67

*See also brief p.14.

Manufacturer	Drug	Quantity	Price to hospitals	Price to druggist
Squibb (Cont.)	Principen-N #9715	100	3.85	12.67
	Principen-N #9745	100	6.50	24.83
	Principen-N #97451	100	6.75	24.83
	Sumycin #6556	1000	13.75	38.50
	Sumycin #65546	100	1.75	4.25
	Sumycin #7634	100	3.15	8.25
	Sumycin #76346	100	3.50	8.25
	Sumycin #8156	60 ml	.42	.90
	Sumycin #8155	480 m.	1.98	4.95
	Penicillin #6346	50	5.88	10.50
	Penicillin #67374	25	6.50	22.50
	Penicillin #7341	per each	.55	1.80
	Penicillin #7353	per each	1.05	3.20
	Penicillin #6846	100	1.99	7.05
Squibb (Cont.)	Penicillin #6384	100	3.95	12.68
	Penicillin #6814	bottle	.49	1.30
	Penicillin #6824	bottle	.69	1.68
	Pentids 300		5.25	6.25
	Pentids P 600 A.S.		5.50	8.25
	Delestrogen 20 mg/cc	per dose (50 doses)	1.22	1.50
	Noctec 7½ gr		2.00	4.20
	Principen 250 mg cap		25.00	91.00
	Principen 500 mg cap		9.25	37.25
	Principen Powder 12		.60	2.18
	Deladuomone 2 cc Unimatic		2.44	2.84
	Sumycin Hydrochloride		168.00	180.00

APPENDIX C

TABLE 1. COMPARISON OF SELECTED PHARMACEUTICAL PRICES IN THE UNITED STATES AND EIGHT FOREIGN COUNTRIES, JANUARY 1970*
(All prices in U.S. dollars for 100 tablets or capsules)
Price to druggist, brand name, and manufacturer

Generic Name	United States	Australia	Brasil
Analgesic: Propoxyphene HCl (65 mg)...	$7.02, Darvon, Lilly.	$2.73, Doloxene, Lilly.	$3.72, Doloxene, Lilly.
Antibiotics:			
Ampicillin (250 mg)	$21.84, Polycillin, Bristol.	$20.48, Penbritin, Bristol.	$41.95, Polycillin, Bristol.
Demethylchlorletracycline HCl (150 mg)	$19.79, Declomycin, Lederle.	$11.17, Ledermycin, Lederle.	$4.93, Ledermicina, Cynamid Quim de Brasil.
Erythromycin (250 mg)	$26.12, Erythrocin, Abbott.	$14.51, Erythrocin, Abbott.	$11.92, Pantomicina, Abbott.
Oxytetracycline HCl (250 mg)	$20.48, Terramycin, Pfizer.	$9.79, Terramycin, Pfizer.	$4.63, Terramicina, Pfizer.
Potassium phenoxymethylpenicillin (250 mg)	$8.95, V-Cillin-K, Lilly.	$6.11, P.V.K., Lilly.	$8.66, V-Cil-K, Lilly.
Tetracycline HCl (250 mg)	$5.34, Achromycin-V, Lederle.	$9.79, Achromy-cin-V, Lederle.	$4.22, Achromy-cin-V, Cyna-mid Quim de Brasil.
Antidepressant: Amitriptyline HCl (25 mg)	$8.55, Elavil, Merck.	$8.33, Tryptanol, Merck.	$2.26, Tryptanol, Merck.
Antidiabetic: Tolbutamide (500 mg) ...	$8.23, Orinase, Upjohn.	$2.83, Rastinon, Hoechst.	$2.77, Rastinon, Hoechst.
Antihistamine: Diphenhydramine HCl (50 mg)	$2.22, Benadryl, Parke-Davis.	$1.60, Benadryl, Parke-Davis.	$0.81, Benadryl, Parke-Davis.
Ataraxics (tranquilizers):			
Chlordiazepoxide HCl (10 mg)	$6.40, Librium, Roche.	$3.74, Librium, Roche.	$2.40, Librium, Roche.
Chlorpromazine HCl (50 mg)	$6.60, Thorazine, SKF.	$2.22, Largactil, May & Baker.	$2.47, Amplictil, Rhodia.
Diazepam (5 mg)	$8.03, Valium, Roche.	$3.74, Valium, Roche.	$3.62, Valium, Roche.
Meprobamate (400 mg)	$7.06, Equanil, Wyeth.	$4.17, Equanil, Wyeth.	$1.91, Equanil, Wyeth.
Prochlorperazine maleate (10 mg) ...	$7.86, Compazine, SKF.	$4.44, Stemetil, May & Baker.	$2.45, Temertil, Rhodia.
Trifluoperazine HCl (5 mg)	$9.75, Stelazine, SKF.	$4.70, Stelazine, SKF.	$2.42, Stelazine, SKF.
Cardiovascular: Digoxin (.25 mg)	$1.03, Lanoxin, B-W.	$0.69, Lanoxin, B-W.	$1.31, Digoxina, B-W.
Oral contraceptive: Ethynodial diace-tate with mestranol (6x21 tabs, 1 mg)	$7.38, Ovulen 21, Searle.	$4.11, Ovulen 21, Searle.	$4.82, Ovulen 21, Searle.
Sedative: Glutethimide (250 mg)	$8.00, Doriden, Ciba.	$2.11, Doriden, Ciba.	$1.97, Doriden, Ciba.
Sulfonamide: Sulfisoxazole (50 mg) ...	$2.94, Gantrisin, Roche.	$3.00, Gantrisin, Roche.	$1.51, Gantrisin, Roche.

Canada	Ireland	Italy	New Zealand	Sweden	United Kingdom
$5.29, Darvon, Lilly.	$1.66, Doloxene, Lilly.	$7.86, Doloxene, Lilly.	$2.08 Doloxene, Lilly.	$3.33, Doloxene, Lilly.	$1.92, Doloxene, Lilly.
$22.18, Ampicin, Bristol.	$9.31, Pentrexl, Bristol.	$19.15, Sintoperyl, Aesculapius.	$11.30, Penbritin, Beecham.	$16.58, Pentrexyl, Bristol.	$8.23, Penbritin, Beecham.
$16.09, Declomycin, Lederle.	$8.87, Ledermycin, Lederle.	$17.88, Ledermicina, Cyanamid.	$3.87, Ledermycin, Lederle.	$19.43, Ledermycin, Lederle.	$8.20, Ledermycin, Lederle.
$25.04, Erythrocin, Abbott.	$8.56, Erythrocin, Abbott.	$24.57, Eritrocina, Abbott.	$10.88, Official Price.	$19.21, Erthromycin, Abbott.	$10.02, Erthromycin, Abbott.
$16.92, Terramycin, Pfizer.	$7.74, Terramycin, Pfizer.	$13.27, Terramicina, Pfizer.	$3.68, Official Price.	$13.04, Terramycin, Pfizer.	$9.06, Terramycin, Pfizer.
$10.69, V-Cillin-K, Lilly.	$2.77, Penicillin-V, Lilly.		$2.99, Official Price.		$2.40, V-Cil-K, Lilly.
$12.64, Achromy-cin-V, Lederle.	$3.42, Achromy-cin-V, Lederle.	$10.84, Achromy-cina, Lederle.	$13.73, Achromy-cin-V, Lederle.	$13.89, Achromy-cin-V, Lederle.	$5.04, Achromy-cin-V, Lederle.
$6.30, Elavil, Merck.	$2.26, Tryptisol, Merck.	$4.22, Triptisol, Merck.	$4.20, Tryptanol, Merck.	$3.09, Tryptisol, Merck.	$2.20, Tryptisol, Merck.
$6.34, Orinase, Hoechst.	$2.22, Rastinon, Hoechst.	$2.86, Rastinon, Hoechst.		$4.86, Rastinon, Hoechst.	$2.28, Rastinon, Hoechst.
$2.77, Benadryl, Parke-Davis.	$1.37, Benadryl, Parke-Davis.	$2.80, Benadryl, Parke-Davis.	$1.29, Official Price.	$2.33, Benadryl, Parke-Davis.	$1.20, Benadryl, Parke-Davis.
$5.45, Librium, Roche.	$2.05, Librium, Roche.	$3.55, Librium, Roche.	$1.83, Librium, Roche.	$3.11, Librium, Roche.	$2.40, Librium, Roche.
$5.82, Largactil, Rhone-Poutenc.	$1.71, Largactil, May & Baker.	$3.47, Largactil, Farmitalia.	$1.82, Official Price.	$2.88, Largactil, Rhodia.	$1.68, Largactil, May & Baker.
$6.01, Valium, Roche.	$2.46, Valium, Roche.	$3.42, Valium, Roche.	$2.72, Official price.	$3.71, Valium, Roche.	$2.88, Valium, Roche.
$5.13, Equanil, Wyeth.	$1.79, Equanil, Wyeth.	$3.65, Quanil, Wyeth.	$2.06, Official price.	$1.67, Equanil, Farrosan.	$1.74, Equanil, Wyeth.
$6.05, Stemetil, Rhone-Poutenc,	$2.87, Stemetil, May & Baker.	$3.04, Stemetil, Farmitalia.	$2.93, Official Price.	$2.28, Stemetil, Leo.	$3.04, Stemetil, SKF.
$8.38, Stelazine, SKF.	$2.78, Stelazine, SKF.	$3.82, Modalina, Maggioni.	$3.71, Official Price.	$4.41, Terfluzin, Rhodia.	$2.59, Stelazine, SKF.
$1.51, Lanoxin, B-W.	$0.53, Lanoxin, B-W.	$1.73, Lanoxin, Wellcome.	$0.52, Official Price.	$0.98, Lanoxin, B-W.	$0.38, Lanoxin, B-W.
$5.85, Ovulen 21, Searle.	$3.59, Ovulen 21, Searle.	$8.20, Ovulenl Leptit.	$3.56, Official Price.	$4.51, Ovulen 21, Searle.	$4.10, Ovulen 21, Searle.
$2.76, Doriden, Ciba.	$0.92, Doriden, Ciba.	$1.80, Doriden, Ciba.	$1.23, Officela Price.	$2.05, Doriden, Ciba.	$1.00, Doriden, Ciba.
$3.06, Gantrisin, Roche.	$1.64, Gantrisin, Roche.	$2.47, Gantrisin, Roche.	$1.11, Gantrisin, Roche.	$2.83, Gantrisin, Roche.	$1.52, Gantrisin, Roche.

* Social Security Bulletin, May, 1971 - Vol. 34, No. 5, U.S. Department of Health, Education & Welfare, S.S. Administration; p 170-171, 967.

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APPENDIX D

NEIGHBORHOOD DRUG STORE PHARMACIES SHOULD BE PRESERVED. IN MANY RESPECTS THEY ARE SUPERIOR TO HOSPITAL PHARMACIES, AND THE CONSUMER SHOULD HAVE THE OPTION TO PATRONIZE THEM IF HE WISHES

There are values worth preserving in corner drug stores. For example:

(a) Drug store pharmacies must be operated by trained and licensed pharmacists,[1] while many hospital drug rooms are staffed by nonpharmacist technicians and clerks.[2] Much hospital dispensation is done by nurses at nursing stations throughout hospitals.[3] Studies have shown that approximately one in six or seven of all medications so dispensed in hospitals is wrong.[4]

[1] Or. Rev. Stat. 689.310: Neighborhood pharmacies are required to comply with the state's Pharmaceutical Services Guide, and are audited by the state and federal government to insure compliance (R. 810).

[2] Francke, Latiolais, Francke & Ho, *Mirror to Hospital Pharmacy* (1964) 68; Fleissner 15; Hastings 13.

[3] Greenlick dep. ex. no. 3, Johnson & Christensen, A Report of The Kaiser Foundation Drug System (1971), 159 (many medication preparation areas are not isolated, but in the central, busiest areas on hospital floors); 155 (32% of the nurses rated hospital drug storing procedures as bad or very bad); 47 (the nursing department assumes responsibility for nearly all inpatient drug distribution, including interpreting and transcribing physicians' drug orders, floor stock drug ordering and receiving, and preparation and administration of individual doses); 174 (no systematic screening of personnel involved in the inpatient drug service system).

[4] Ibid., fn. 3, 262; Tester, William W., A Report of the Iowa Drug Distribution System, *Drug Intelligence, II*, Nov. 1968, pp. 305-309; Stewart & Cluff, A Review of Medication Errors and Compliance in Ambulant Patients, *13 Clinical Pharmacology and Therapeutics* (July-August 1972) 463, 465; Barker & McConnell, How to Detect Medication Errors, 99 *Modern Hospitals* 95-106 (1962).

(b) Respondent agrees there is a problem in getting the patients to follow prescribed drug regimen.[5] However, studies have also shown that patient compliance increases where there is oral contact between pharmacist and patient.[6] There is a greater likelihood of this between the neighborhood pharmacist than in the clinical hospital pharmacy environment.

(c) There are still many hospitals having no pharmacists.[7] Such is not the case with drug stores, where a trained pharmacist must be employed.[8]

(d) If drug store pharmacies are phased out it will be necessary to obtain medication from the hospital. This may mean considerable travel. Studies at Kaiser Hospital have indicated the average travel time is approximately 18 minutes to reach the hospital pharmacy.[9]

(e) Many hospital pharmacies are cramped. Some lack recommended equipment.[10] There have

[5] Marston 19, *Nursing Research* 312 (1970).

[6] Sharpe & Mikeal, Compliance with Medical Regimens, *31 Am. Journal Hospital Pharmacy* (1974) 479, Patient Compliance with Antibiotic Regimens.

[7] Francke, Latiolais, Francke & Ho, *Mirror to Hospital Pharmacy* 68 (1964); Fleissner 15; Hastings 13.

[8] Ibid., fn. 1.

[9] Ibid., fn. 3, 480.

[10] Francke, Latiolais, Francke & Ho, supra, 67 (more than 50% of the nation's pharmacies in hospitals with 200 or more beds, including more than 500 hospitals with from 300 to more than 500 beds, do not have the space or equipment recommended by the Public Health Service for the pharmacy in a 200-bed hospital. This is also true of hospitals

also been complaints of extended waiting.[11]

(f) There is no certainty that if drug stores disappear, costs will not increase at hospital pharmacies. Average cost of treatment in hospital outpatient clinics is nearly twice as much as that in a private physician's office.[12] There is also no assurance the doctor one sees at the hospital is superior to the doctor one might see in his own neighborhood. Approximately 15% of the nation's hospital physicians are interns or residents;[13] 35% of these are recruited from abroad, where their training is often inferior to that in the U.S.[14]

The American pharmacist is a resource of inestimable value, whose talent has not yet been fully tapped.[15] It has been said that the pharmacist is the

with 100 beds.); Somers, *119 Mod. Hospital* 95 (June 1972) ("Some [hospitals], especially some of our big city municipal institutions, are incredibly poor.")

[11] Bodenheimer, *VII Inquiry* 26, 33 (Sept. 1970); Ibid., fn. 41, 486; Hearings, supra, 179.

[12] Editorial, The Hospital's Responsibility for Primary Care, *2 Hosp. Med. Staff* (Jan. 1973) at 1.

[13] Knowles, The Hospital, *Scientific American* 128, 135 (Sept. 1973).

[14] Ibid.

[15] Brodie & Graber, Institutional Pharmacy in the 1970's, 28 Amer. Journal of Hospital Pharmacy 240, 243-4 (1971) ("if the pharmacists' present background were supplemented with specialized training, a large unexplored area of service would undoubtedly be opened up. The pharmacist is usually the next best educated person in the hospital, second only to the physician, and yet he is usually poorly used. It is only reasonable to believe that some pharmacists—*either in or out of the hospital*—will be shifted into areas of service made critical by the physician shortage. One has only to reflect on the fact that there are 35,000 pharmacists in the United States who graduated from pharmacy school since 1960 to realize the potential that this reservoir has for relieving

second best educated person in hospitals.[16] The educational backgrounds of neighborhood pharmacists and hospital pharmacists are identical.[17]

While we are being reminded that we face a severe physician shortage,[18] and serious proposals are being made to reduce the education required for physicians from 8 to 6 years,[19] petitioners are impliedly suggesting we can well dispense with neighborhood pharmacists.

It is dubious that hospitals are fully prepared to handle the crunch which will surely follow if the 1½ billion prescriptions which are being filled at drug stores[20] are suddenly shifted to hospital pharmacies. Many hospital parking lots are crowded now. Moreover, the hours of operation at hospital pharmacies may not be as advantageous as those offered at drug stores. Some close at 5:00 p.m.[21] Others are not open on Sundays, etc.[22] Can we be sure that those who urgently need medications will receive help in time if there is no corner drug store?

Drug stores are not always open either. But al-

some of the problems created by the physician shortage.") (Underlining supplied).

[16] Hearings, supra, 131 (Hospital pharmacists have the same academic background, and same number of hours in pharmacy school.); see fn. 15, supra.

[17] Fn. 16, supra.

[18] Brodie & Graber, supra, 245 (discussing the Carnegie Commission's recent report.)

[19] Ibid.

[20] Gosselin, *West Coast-Rocky Mountain Druggist* (July 1975) 29.

[21] Chartier, 15; Neal, 10.

[22] Chartier, 15; Neal, 10.

most all in Portland offer emergency home delivery to those with an immediate need.[23] There is no indication that any of the hospital pharmacies in Portland do so.

In addition, if drug stores fade and are replaced by those operated by nonprofit hospitals, the tax revenue generated by drug stores will fade too. Do hospitals, which pay no taxes, need drug price favoritism as well when they have no intent to use such drugs for hospital uses?

The average drug store pharmacy carries many more items than those carried by hospital pharmacies.[24] Most hospitals use a formulary, which means that the drugs stocked are confined to those listed on the formulary.[25] Many physicians have expressed their displeasure and have preferred community pharmacies for that very reason.[26]

It has also been noted that where hospitals engage in extensive filling of prescription for nonpatients, these are the ones which are often filled first, rather than the more acute inpatients.[27]

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[23] R. 646.

[24] There are, for example, more than 170,000 separate items listed in the Red and Blue Books, the standard catalogues in the industry (Hearings, supra, 341), though most neighborhood pharmacies carry only 3000 drugs. (Hearings, supra 130). At that, however, it is still more than the average of 300-400 drugs carried by some hospital pharmacies. (Merrill, *Hospitals* (June 1941) 33-34).

[25] Merrill, *Hospitals* (June 1941) 33, 34.

[26] Dr. Merrill has written (Hospitals 33, 34 (June 1941)): "A formulary of limited scope and standardized preparations cannot contribute to this desirable practice and would restrict the physician to substandard treatment."

[27] Ibid., fn. 3, 51.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 74-1274

ABBOTT LABORATORIES, *et al.*,

Petitioners,

—v.—

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF FOR AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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28

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MOTION OF THE AMERICAN HOSPITAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE*

Pursuant to Rule 42 of the Rules of this Court, the American Hospital Association hereby respectfully moves this Court for leave to file the attached brief *amicus curiae* in the above-captioned case. The brief urges reversal of the decision of the Court of Appeals for the Ninth Circuit in the above-entitled case.

Counsel for the petitioners have consented to the filing of the attached brief. Counsel for the respondent have not consented to its filing.

The American Hospital Association

The American Hospital Association ("AHA") is a nonprofit organization which represents some 7,500 institutional members (hospitals and other health care institutions) and more than 16,000 personal members. The purpose of the AHA is stated in its first bylaw:

> "[The AHA] object shall be to promote the welfare of the public through its leadership and its assistance to its members in the provision of better health care services for all the people."

The organization's principal interest is the care which patients receive from the hospitals of this country.

AHA provides a wide range of professional services in order to develop "better health services for all the people." It, along with the American College of Surgeons, the American College of Physicians, and the American Medical Association, is a sponsor of the Joint Commission on Accreditation of Hospitals, an organization which assists hospitals in their efforts to provide optimal levels of care. AHA conducts a considerable number of educational programs, such as workshops, institutes and meetings, to assist its members in providing efficient hospital care. It publishes and distributes substantial amounts of professional literature on the same subject. AHA conducts the most extensive data collection program in the hospital field and a wide range of hospital research projects.

AHA also represents its membership with respect to governmental matters before the Congress and such federal agencies as the Department of Health, Education, and Welfare.

The Interest of the American Hospital Association as *Amicus Curiae*

The decision of the Court of Appeals for the Ninth Circuit is of profound significance to all nonprofit hospitals and the AHA. It is the first judicial application of the Nonprofit Institutions Act to hospitals. It has massive precedential consequences. The decision attempts to list every type of drug use by nonprofit hospitals and then to determine, in broad and absolute terms, the application of the Act's Robinson-Patman exemption to each type of drug use. This is not a decision limited to a particular type of drug usage by a particular type of nonprofit hospital. The decision threatens to affect all nonprofit hospitals, not just in the Ninth Circuit, but all across the nation.

Yet it is the nonprofit hospitals whose interests have not been represented in the prior proceedings in this action. With all respect to the respondent assignee of various retail druggists, and to the petitioner drug manufacturers, it is the nonprofit hospitals represented by AHA that would feel the real brunt of the decision.

The Nonprofit Institutions Act was enacted to confer important benefits upon nonprofit hospitals, namely, the opportunity to purchase drugs and other supplies at special low prices in order to enable the hospitals to operate as inexpensively as possible. It is surely appropriate that the AHA be given the opportunity to convey to the Court its views with respect to the application of this important exemption to nonprofit hospitals.

The AHA believes that the decision is fundamentally unsound. It is inherently illogical. It relies on a rigid, categorical approach to determine which drugs are pur-

chased for a hospital's "own use" and thereby qualify for the exemption, and which drugs do not qualify for the exemption even though they are used to treat sick people in the performance of admittedly proper hospital functions. The eight listed categories do not even cover the present range of hospital drug usage. And the arbitrary line of demarcation between exempt and nonexempt categories is never explained; it is in fact inexplicable.

The practical consequences of compliance with the decision would be enormous and costly. No matter how the decision were implemented, it would result in higher drug costs, higher administrative costs and substantive disruption of services and supply procedures.

The AHA further believes that the decision of the Court of Appeals is premised on an inaccurate understanding of the functions of a hospital in contemporary society. Public and private health care experts, the Congress, and the federal health care agencies agree that the present gap in health care services can only be narrowed if the hospital becomes the primary source for total community health services. The decision is flatly inconsistent with the ongoing expansion of outpatient and ambulatory services by hospitals—a vital development in the delivery of health care in this country.

This Court granted AHA's motion for leave to file a brief *amicus curiae* in support of the petition for a writ of certiorari in this case. Now that the case is being heard on the merits, AHA wishes to bring to the Court's attention the experience and views of the nonprofit hospitals who would be affected by the decision most directly.

Accordingly, the American Hospital Association respectfully urges this Court to grant its motion for leave to file its brief as *amicus curiae*.

Respectfully submitted,

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Cain v. *Bowlby*, 114 F.2d 519 (10th Cir.), *cert. denied*, 311 U.S. 710 (1940) 10

Commonwealth v. *Tilley*, 306 Mass. 412, 28 N.E.2d 245 (1940) 10

De Lima v. *Bidwell*, 182 U.S. 1 (1901) 10

Eastern Kentucky Welfare Rights Organization v. *Simon*, 506 F.2d 1278 (D.C. Cir. 1974), *cert. granted*, 95 S. Ct. 1974 (1975) (Nos. 74-1110 and 74-1124) 9, 12

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Fortnightly Corp. v. *United Artists Television, Inc.*, 392 U.S. 390 (1968) 11

Heart of Atlanta Motel, Inc. v. *United States*, 379 U.S. 241 (1964) 9

Hospital Building Co. v. *Trustees of Rex Hospital*, 511 F.2d 678 (4th Cir. 1975), *petition for cert. filed*, 43 U.S.L.W. 3626 (U.S. May 19, 1975) (No. 74-1452) 27

Logan Lanes, Inc. v. *Brunswick Corp.*, 378 F.2d 212 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967) 5, 6, 8, 23, 24, 25

Newman v. *Arthur*, 109 U.S. 132 (1883) 10

Pickhardt v. *Merritt*, 132 U.S. 252 (1889) 10

Jerome H. Remick & Co. v. *Am. Auto. Accessories Co.*, 5 F.2d 411 (6th Cir.), *cert. denied*, 269 U.S. 556 (1925) 10

Todd v. *Citizens' Gas Co.*, 46 F.2d 855 (7th Cir.), *cert. denied*, 283 U.S. 852 (1931) 10

Statutes and Regulations:

42 U.S.C. § 242h (Supp. III, 1973) 20

§ 2002 (1970) 20

Medical Facilities Construction and Modernization Amendments of 1970, 42 U.S.C. § 291c(a)(5) 14

National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 2(a)(4), 88 Stat. 2226 14

PAGE

Nonprofit Institutions Act, 15 U.S.C. § 13c (1970) ....*passim*

Public Health Service Amendments of 1968, Pub. L. No. 90-574, 82 Stat. 1005 14

Robinson-Patman Act, 15 U.S.C. §§ 13 *et seq.* (1970) ..*passim*

Internal Revenue Service

Rev. Rul. 68-376, 1968-2 CUM. BULL. 246 .....25, 4a-7a

Rev. Rul. 69-267, 1969-1 CUM. BULL. 160 28

Rev. Rul. 69-268, 1969-1 CUM. BULL. 160 28

Rev. Rul. 69-269, 1969-1 CUM. BULL. 160 28

Cost of Living Council Regulations, 39 Fed. Reg. 2670 (1974) 14

Legislative Materials:

H.R. Rep. No. 2161, 75th Cong., 3d Sess. (1938) 4, 8

S. Rep. No. 1769, 75th Cong., 3d Sess. (1938) 4, 8

S. Rep. No. 1454, 90th Cong., 2d Sess. (1968) 14

Other Authorities:

37 Soc. Sec. Bull. No. 2, Table 2 (February 1974) 19

Board of Trustees, Am. Hosp. Ass'n, *Statement on the Changing Hospital and the American Hospital Association,* 39 HOSPS., July 1, 1965, at 35 13

Bodenheimer, *Patterns of American Ambulatory Care,* VII INQUIRY, Sept., 1970 at 26 17

PAGE

Brodie & Graber, *Institutional Pharmacy Practice in the 1970's,* 28 AM. J. HOSP. PHARMACY 240 (1971) 13, 27

CENTER FOR COMMUNITY HEALTH SYSTEMS, COLUMBIA UNIVERSITY, COMMUNITY HOSPITALS AND THE CHALLENGE OF PRIMARY CARE (1975) 14

Clarke, *Medications for Outpatients: Operating a Successful Dispensary,* 20 HOSPS., Oct., 1946, at 60 9

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, A REPORT TO THE PRESIDENT ON MEDICAL CARE PRICES (1967) 14

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, INCLUSION OF PHARMACEUTICAL SERVICES IN HEALTH MAINTENANCE AND RELATED ORGANIZATIONS, DHEW Publication No. (HSA) 74-13017 (1974) 26

Editorial, 216 J.A.M.A. 972 (1971) 14

Editorial, *The Hospital's Responsibility for Primary Care,* 2 HOSP. MED. STAFF, Jan., 1973, at 1 12

Madden, *Evaluation of Outpatient Pharmacy Patient Counselling,* NS13 J. AM. PHARMACEUTICAL ASS'N 437 (1973) 29

Marston, *Compliance With Medical Regimens: A Review of the Literature,* 19 NURSING RESEARCH 312 (1970) 28

Martin, *Control of Out-Patient Service and Charges,* HOSPS., Sept., 1942, at 85 9

Merrill, *Hospital Pharmacy and Out-Patient Department: The Physician's Point of View,* HOSPS., June, 1941, at 33 9

PAGE

NATIONAL ADVISORY COMMISSION ON HEALTH FACILITIES, A REPORT TO THE PRESIDENT (1968) 14

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, FINANCIAL PLANNING IN AMBULATORY HEALTH PROGRAMS, Publication No. (HSM) 73-3027 (1973) 14

Perkoff & Anderson, *Relationship between Demographic Characteristics, Patient's Chief Complaint, and Medical Care Destination in an Emergency Room*, VIII MED. CARE 309 (1970) 17

Piore, *Problems and Opportunities for Community Hospitals in Primary Care*, CENTER FOR COMMUNITY HEALTH SYSTEMS, COLUMBIA UNIVERSITY, COMMUNITY HOSPITALS AND THE CHALLENGE OF PRIMARY CARE (1975) 11, 12, 15, 1a-3a

REPORT OF THE NATIONAL COMMISSION ON COMMUNITY HEALTH SERVICES (1967) 14

F. ROWE, PRICE-DISCRIMINATION UNDER THE ROBINSON-PATMAN ACT (1962) 27

Sharpe & Mikeal, *Patient compliance with antibiotic regimens*, 31 AM. J. HOSP. PHARMACY 479 (1974) 28

Somers, *Only the hospital can do it all—now*, 119 MOD. HOSP., July, 1972, at 95 13

H. M. & A. R. SOMERS, MEDICARE AND THE HOSPITALS: ISSUES AND PROSPECTS (1967) 12

Stewart & Cluff, *A review of medication errors and compliance in ambulant patients*, 13 CLINICAL PHARMACOLOGY AND THERAPEUTICS 463 (1972) 29

IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 74-1274

ABBOTT LABORATORIES, *et al.*,

Petitioners,

—v.—

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Interest of *Amicus Curiae*

The interest of the American Hospital Association as *amicus curiae* is set forth in the preceding motion for leave to file this brief.

Question Presented

Is the Nonprofit Institutions Act exemption for drugs purchased by nonprofit hospitals "for their own use" limited solely to drugs dispensed to inpatients and patients in the emergency clinic?

Statement of the Case

1. *The Proceedings Below*

Respondent, as the assignee of claims from sixty retail pharmacies, filed this action against twelve drug manufacturers seeking treble damages and injunctive relief. Respondent alleged, *inter alia,* that petitioners had engaged in unlawful price discrimination in violation of the Robinson-Patman Act, 15 U.S.C. §§ 13 *et seq.* (1970), by selling drugs to nonprofit hospitals at prices lower than those offered to commercial retail pharmacies.

Petitioners moved for summary judgment on this claim on the ground that the Nonprofit Institutions Act, 15 U.S.C. § 13c (1970), exempts drug purchases by nonprofit hospitals from the application of the Robinson-Patman Act. The District Court agreed and granted petitioners' summary judgment motion on May 25, 1973. (Tr. 5/25/73 at 88-99) The Court of Appeals for the Ninth Circuit, however, disagreed and vacated the judgment of the District Court on December 26, 1974. 510 F.2d 486.

The drug manufacturers filed a petition for rehearing, and the American Hospital Association sought to file a brief in support of their petition. On March 11, 1975, the Court of Appeals denied both the petition for rehearing and AHA's motion for leave to file its brief as *amicus curiae.* Thereafter, the drug manufacturers petitioned this Court for a writ of certiorari. The AHA sought leave to support the petition *amicus curiae.* On June 23, 1975, the writ, and AHA's motion for leave to file its brief were granted.

2. *The Decision of the Court of Appeals*

The Court of Appeals vacated the judgment below because it interpreted the scope of the Nonprofit Institutions Act ("the Act" or "Section 13c") more narrowly than the District Court. The issue, as framed by the Court of Appeals, was whether each of eight categories of drugs purchased by hospitals was "for their own use" within the meaning of Section 13c. The appellate court concluded that only two categories—drugs dispensed to inpatients and to emergency clinic patients—were for the hospitals' "own use," and hence covered by the Section 13c exemption to the Robinson-Patman Act. The court conceded that the remaining six categories, including dispensation of drugs to outpatients at outpatient clinics, to departing inpatients as take-home prescriptions, and to other patients and users of medication, were "a proper and useful community service and thus can be regarded as a proper hospital function." 510 F.2d at 489. But the court held without explanation that such uses were not the hospitals' "own use" and therefore did not qualify for the Section 13c exemption:

> "Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of in-patients or emergency patients. The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer." *Id.*

Summary of Argument

The Nonprofit Institutions Act exempts from the price discrimination provisions of the Robinson-Patman Act purchases by hospitals and other nonprofit institutions of "supplies for their own use." The issue in this case is whether the Nonprofit Institutions Act exemption is limited solely to *horizontal* drug usage, that is, to drugs dispensed to inpatients and emergency clinic patients, and is inapplicable to *vertical* drug usage, that is, to drugs dispensed to other categories of sick persons, such as those who are treated in outpatient clinics.

The Ninth Circuit summarily concluded that only drugs dispensed to inpatients and emergency clinic patients qualify for the Robinson-Patman exemption. All other drugs purchased by hospitals, though concededly used to perform "proper hospital function[s]," were deemed to be outside the scope of the exemption.

1. The Ninth Circuit would confine the scope of the Section 13c exemption to the principal activities performed by hospitals nearly forty years ago, when the exemption was enacted. Such a frozen interpretation of the statute would be inconsistent with its broad beneficent purposes. The legislative history makes clear that the purpose for the exemption lay in the nonprofit character of the beneficiary institutions, not in the particular activities of such institutions in 1938.[1] The Ninth Circuit's static reading would frustrate the intent of Congress to permit nonprofit insti-

[1] H.R. Rep. No. 2161, 75th Cong., 3d Sess. (1938); S. Rep. No. 1769, 75th Cong., 3d Sess. (1938).

tutions "to operate as inexpensively as possible."[1] The Section 13c exemption should be coterminous with the contemporary functions of the beneficiary institutions.

2. The hospital of today offers a wide range of health care services. At the urging of health care experts and the Federal Government, and in response to a growing gap between health care needs and health care resources, it is providing more and more care through outpatient clinics and other ambulatory care facilities.

3. The Ninth Circuit decision is incompatible with these important developments in the delivery of health care. By means of a rigid, categorical approach, the decision would deny the Section 13c exemption to drugs used in treating outpatients and in performing other proper hospital functions. There is no difference between a hospital's use of drugs in treating inpatients and in treating outpatients. In both cases, the hospital is using the drugs to cure sick people. In neither case does the hospital "consume" the drug. In both cases, it is the patient—inpatient or outpatient—who does so. In both cases the hospital purchases the drug for resale to the patient. And in both cases the hospital is engaging in a "proper hospital function," as the Court of Appeals conceded. By what logic, then, can the Section 13c exemption be accorded to drugs used to treat inpatients but denied to drugs used to treat outpatients?

4. Section 13c was intended to confer benefits upon certain nonprofit institutions. However, the decision below would convert Section 13c benefits into burdens of con-

[1] *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212, 216 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967).

siderable magnitude. The decision would oblige hospitals either to create and operate duplicate inventory and distribution systems for drugs and other hospital supplies, or to trace the uses to which a single inventory of drugs and supplies are put. The sheer quantity of drugs and supplies stocked by a hospital, and the multiplicity of suppliers furnishing them, would make either option a formidable administrative task. Alternatively, a hospital could simply pay higher prices for all of its drugs and other supplies, and thus forego all of the benefits which Section 13c was intended to confer.

5. The decision below is wrong not merely in result but in approach. A categorical methodology is simply unsuited to Section 13c. The controlling question should not be whether there are six or eight or ten categories of hospital drug usage, or whether each category involves hospital "consumption" of drugs.

Rather, the controlling question should be this: What is the *primary purpose* of the drugs purchased by the hospital? If the primary purpose is the treatment of hospital patients or the performance of other legitimate hospital functions, then the Section 13c exemption should apply to all drugs purchased by the hospital.

The primary purpose test, adopted by the Ninth Circuit in an earlier decision, *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212, *cert. denied*, 389 U.S. 898 (1967), is eminently sensible and should be endorsed by this Court. It would accord nonprofit institutions the price benefits Congress intended to confer without shackling their ability to fulfill their institutional purposes. It would make it unnecessary for the judiciary to determine what are proper institutional functions, and to identify every use to which

every nonprofit institution purchase is put. It would also eliminate the illusory distinction between purchases for an institution's "proper function" and purchases for its "own use."

6. It is uncontroverted that the drugs in issue were purchased primarily for the treatment of hospital patients. The treatment of hospital patients is unquestionably a proper activity for a hospital. Therefore, we submit, the Section 13c exemption applies to all of the drugs in issue. The Ninth Circuit's contrary holding should be reversed.

ARGUMENT

I.

The Nonprofit Hospital Exemption Is Coextensive With the Functions of a Hospital in Contemporary Society.

The Nonprofit Institutions Act, 15 U.S.C. § 13c (1970), was enacted in 1938 to exempt hospitals and other nonprofit institutions from the price discrimination prohibitions of the Robinson-Patman Act in order to allow such institutions to purchase their supplies on preferential terms. It provides that:

> "Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."

As the Court of Appeals for the Ninth Circuit has interpreted this provision, the Section 13c exemption would be confined to the principal activities performed by hospitals

nearly 40 years ago. Without reference to the realities of modern-day practice, the court determined that only drugs provided by hospitals to inpatients and emergency clinic patients may be said to have been purchased by the hospital for its "own use," within the meaning of Section 13c. All other hospital uses of drugs and other supplies—such as drugs used by hospitals in treating outpatients—though conceded to be "proper hospital function[s]" are nevertheless held to be outside the scope of the exemption.

This frozen definition of a hospital's "own use" of drugs is inconsistent with the broad beneficent purposes of the statutory exemption. The legislative history of the Nonprofit Institutions Act makes clear that the purpose and justification for the exemption lay in the nonprofit character of the beneficiary institutions listed in the law, not in the particular activities of such institutions in 1938:

> "The committee does not feel that the wholesome purpose of the Robinson-Patman Act will be interfered with by the enactment of this bill to make certain that favors in price which are occasionally extended to eleemosynary institutions, *because of the character of the institution,* do not fall under the ban of the act." [1]

Furthermore, "[t]he underlying intent of granting such an exemption was undoubtedly to permit institutions which are not in business for a profit to operate as inexpensively as possible." [2] Congress did not intend to limit a nonprofit institution's "own use" of supplies to those particular activities which schools, libraries, churches and hospitals were in fact conducting on the date of enactment of Section 13c.[1] Such static statutory construction would substantially impair the ability of the beneficiary institutions to continue to operate inexpensively under the changed circumstances which inevitably come with the passage of time.

[1] H.R. Rep. No. 2161, 75th Cong., 3d Sess. (1938) (emphasis supplied). *See also,* S. Rep. No. 1769, 75th Cong., 3d Sess. (1938).

[2] *Logan Lanes, Inc.* v. *Brunswick Corp.,* 378 F.2d 212, 216 (9th Cir.), *cert. denied,* 389 U.S. 898 (1967).

The Court of Appeals for the D.C. Circuit recently reached the same conclusion in an analogous context in *Eastern Kentucky Welfare Rights Organization* v. *Simon.*[2] The issue was whether the term "charitable," as used in § 501(c)(3) of the Internal Revenue Code, was to be restricted to its narrow sense of relief of the poor. The court held that definitions of charitable institutions must change with the times:

> "We cannot conclude, as did the district court, that Congress intended the [narrow] construction. While it is true that in the past Congress and the federal courts have conditioned a hospital's charitable status on the level of free or below cost care that it provided for indigents, there is no authority for the conclusion that the determination of 'charitable' status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary society." [3]

[1] Though not as predominant or important as they are today, outpatient departments were nevertheless an integral part of the hospital forty years ago. In 1941, one physician wrote, "It is almost superfluous to emphasize that the pharmacy and out-patient department are among the most essential services of a hospital." Merrill, *Hospital Pharmacy and Out-Patient Department: The Physician's Point-of-View,* Hosps., June, 1941, at 33. *See also,* Clarke, *Medications for Outpatients,* 20 Hosps., Oct., 1946, at 60; Martin, *Control of Out-Patient Service and Charges,* Hosps., Sept., 1942, at 85.

[2] 506 F.2d 1278 (D.C. Cir. 1974), *cert. granted,* 95 S. Ct. 1974 (1975) (Nos. 74-1110 and 74-1124).

[3] *Id.* at 1287-88 (footnote omitted); *cf. Heart of Atlanta Motel, Inc.* v. *United States,* 379 U.S. 241, 249-58 (1964).

The courts have consistently refused to circumscribe the scope of a statute by reference to the conditions in existence at the time of its enactment.[1] In *Browder* v. *United States,* 312 U.S. 335 (1941), this Court was asked to set aside a criminal conviction for the use of a passport which had been obtained by false statements. The defendant had used the passport to reenter the United States, a use that had not been customary at the time the criminal statute was enacted. It was therefore argued that Congress had not intended to punish uses such as that for which the defendant was convicted.

The Court rejected this contention:

> "Old laws apply to changed situations. The reach of the act is not sustained or opposed by the fact that it is sought to bring new situations under its terms. While a statute speaks from its enactment, even a criminal statute embraces everything which subsequently falls within its scope."[2]

It is a basic rule of statutory construction that a "statute may be applied to new situations not anticipated by Congress, if, fairly construed, such situations come within its intent and meaning."[3] Thus, we submit, television sets purchased by schools and Xerox machines purchased by

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[1] *See, e.g., De Lima* v. *Bidwell,* 182 U.S. 1, 197 (1901); *Pickhardt* v. *Merritt,* 132 U.S. 252, 257 (1889); *Newman* v. *Arthur,* 109 U.S. 132, 138 (1883); *Cain* v. *Bowlby,* 114 F.2d 519, 522 (10th Cir.), *cert. denied,* 311 U.S. 710 (1940); *Todd* v. *Citizens' Gas Co.,* 46 F. 2d 855, 865 (7th Cir.), *cert. denied,* 283 U.S. 852 (1931); *Jerome H. Remick & Co.* v. *Am. Auto. Accessories Co.,* 5 F.2d 411 (6th Cir.), *cert. denied,* 269 U.S. 556 (1925); *Commonwealth* v. *Tilley,* 306 Mass. 412, 415-16, 28 N.E.2d 245, 247 (1940).

[2] 312 U.S. at 339-40 (footnotes omitted).

[3] *Jerome H. Remick & Co.* v. *Am. Auto. Accessories Co.,* 5 F.2d 411 (6th Cir.), *cert. denied,* 269 U.S. 556 (1925).

libraries are entitled to the 13c exemption even though schools and libraries may not have used such equipment in 1938. Guitars purchased for a church "Folk Mass" are for the church's "own use," and hence are also within the 13c exemption, even if such a church function was unheard of in 1938.

Similarly, drugs used by nonprofit hospitals today are entitled to the 13c exemption even when purchased for uses which had not developed, or were not widespread, in 1938.

As this Court has stated:

> "While statutes should not be stretched to apply to new situations not fairly within their scope, they should not be so narrowly construed as to permit their evasion because of changing habits due to new inventions and discoveries."[1]

If the beneficent purpose of the Nonprofit Institutions Act is to be realized, and if public service institutions are to operate inexpensively, as the Congress intended, the exemption must be coextensive with the present-day functions of the beneficiary institutions.

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[1] *Fortnightly Corp.* v. *United Artists Television, Inc.,* 392 U.S. 390, 395 n.16 (1968).

II.

The Ninth Circuit Decision Ignores the Realities of Present-Day Medical Practice.

The decision of the Court of Appeals is incompatible with the functions of a hospital in contemporary society. The hospital today occupies the central position in the health care system.[1] It is no longer a facility devoted chiefly to the care of inpatients, the acutely ill, or the indigent; it is now a health center "encompassing and integrating the wide range of comprehensive medical services—prevention, treatment, rehabilitation, and aftercare."[2]

The expanded role has, in large part, been thrust upon hospitals.[3] In recent decades, a confluence of factors—*e.g.*, demographic changes, shortages of general practitioners (particularly in inner city and rural communities), the increasing inability of many to afford private medical care, and the trend toward physician specialization—have caused critical problems in the delivery of health care.[4]

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[1] *Eastern Kentucky Welfare Rights Organization* v. *Simon*, 506 F.2d 1278, 1288 (D.C. Cir. 1974), *cert. granted*, 95 S. Ct. 1974 (1975) (Nos. 74-1110 and 74-1124).

[2] H. M. & A. R. Somers, Medicare and the Hospitals—Issues and Prospects 43 (1967). *See also*, Editorial, *The Hospital's Responsibility for Primary Care*, 2 Hosp. Med. Staff, Jan., 1973, at 1.

[3] Piore, *Problems and Opportunities for Community Hospitals in Primary Care*, Center for Community Health Systems, Columbia University, Community Hospitals and the Challenge of Primary Care 15 (1975).

[4] See Appendix 1, *infra*, for a summary of factors causing the increase in ambulatory visits to hospitals, reprinted from Piore, *Problems and Opportunities for Community Hospitals in Primary Care*, Center for Community Health Systems, Columbia University, Community Hospitals and the Challenge of Primary Care 18-19 (1975).

Inevitably, it has been the hospital to which the community has turned for the solution to the growing crisis.[1] In 1965, the Board of Trustees of the American Hospital Association summarized the need for change this way:

> "[The] changing needs of the public are demanding a changing hospital.
>
> • • • •
>
> " . . . *The hospital now must be . . . an organized arrangement of all medical resources* necessary to bring the individual, wherever located, into contact with the skills of the physician and other members of the health care team. It must serve as an arrangement by which our communities . . . make available medical, nursing, and other professional care for the prevention, diagnosis, and treatment of disease, and eventually for the rehabilitation of the sick and injured, when these resources are beyond the capabilities of the individual patient or physician. . . . *This hub, the general hospital, cannot function independently of the other elements within the circle of organized hospital care activity, such as the outpatient departments, emergency departments, home care programs, and long-term care facilities.*"[2]

AHA's analysis was not revolutionary. The concept of the hospital as the hub of community health care services has been urged by health care authorities for years.[3] Today, Federal agencies and commissions, along with pri-

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[1] *See* Somers, *Only the hospital can do it all—now*, 119 Mod. Hosp., July, 1972, at 95.

[2] 39 Hosp., July 1, 1965, at 35a (emphasis supplied). *See* Brodie & Graber, *Institutional Pharmacy Practice in the 1970's*, 28 Am. J. Hosp. Pharmacy 240, 241 (1971).

[3] Somers, *Only the hospital can do it all—now*, 119 Mod. Hosp., July, 1972, at 96.

vate health care experts, forcefully advocate health care facilities which place "particular emphasis on primary, ambulatory care." [1]

Congress, too, has consistently urged the expansion of ambulatory health care facilities.[2]

In response to such urging, hospitals have substantially expanded their outpatient and ambulatory services. Last year, nearly a quarter of a billion outpatient visits were made to U.S. hospitals—more than one for every American.

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[1] NATIONAL ADVISORY COMMISSION ON HEALTH FACILITIES—A REPORT TO THE PRESIDENT (1968). *See also* NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, FINANCIAL PLANNING IN AMBULATORY HEALTH PROGRAMS, Publication No. (HSM) 73-3027 (1973); REPORT OF THE NATIONAL COMMISSION ON COMMUNITY HEALTH SERVICES (1967); DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, A REPORT TO THE PRESIDENT ON MEDICAL CARE PRICES 4 (1967); CENTER FOR COMMUNITY HEALTH SYSTEMS, COLUMBIA UNIVERSITY, COMMUNITY HOSPITALS AND THE CHALLENGE OF PRIMARY CARE (1975); Editorial, 215 J.A.M.A. 972 (1971). Even the Cost of Living Council took steps to encourage ambulatory care when, in 1974, it issued revised price regulations for hospitals "[i]n order not to discourage the trend towards increased use of outpatient services." 39 Fed. Reg. 2670, 2697 (1974).

[2] For example, in connection with the Public Health Service Amendments of 1968, Pub. L. No. 90-574, 82 Stat. 1005, Congress noted the need for "ambulatory-care facilities, such as outpatient departments of hospitals . . . to negate the necessity of constructing additional inpatient facilities and . . . to control the cost of delivering medical care." S. Rep. No. 1454, 90th Cong., 2d Sess. (1968). Two years later, in the Medical Facilities Construction and Modernization Amendments of 1970, 42 U.S.C. § 291e(a)(5), Congress specifically provided by statute that priority in construction be given "to projects for facilities which . . . will . . . [include] outpatient and preventive care as well as hospitalization." And only recently, Congress complained in Section 2(a)(4) of the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2226, that "there are presently inadequate incentives for the . . . substitution of ambulatory and intermediate care for inpatient hospital care."

On an average day, 87,000 people are admitted as inpatients to community hospitals, while nearly half a million people are treated in these hospitals' clinics and emergency rooms. There were 2.3 ambulatory visits for every inpatient admission in 1953; the ratio has now more than doubled to 5.6 to 1. And the trend is continuing. From 1968 to 1973 alone, the number of visits has increased by 57 percent.[1] It is clear that

> "care of the ambulatory patient for both minor ailments and serious illnesses has become a major function of the modern hospital establishment and a significant part of general medical care for large numbers of people." [2]

III.

The Decision Below Draws Distinctions Which Are Arbitrary and Illusory.

The Ninth Circuit decision ignores the foregoing developments and the manifold role of today's hospital in the delivery of health care services. It holds that drugs are purchased for the hospital's "own use" and are entitled to the Section 13c exemption only when the drugs are consumed by persons lying in a horizontal position—in a hospital bed or in the emergency clinic. The drugs consumed by persons in a vertical position—upon discharge from the hospital or in an outpatient clinic—are denied the Section 13c exemption. This makes no sense.

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[1] Piore, *Problems and Opportunities for Community Hospitals in Primary Care*, CENTER FOR COMMUNITY HEALTH SYSTEMS, COLUMBIA UNIVERSITY, COMMUNITY HOSPITALS AND THE CHALLENGE OF PRIMARY CARE 16 (1975).

[2] *Id.*

Even if hospitals provided only inpatient care, this distinction would be arbitrary. But in light of the functions of a modern hospital—where outpatient care is an integral part of hospital health care services—the distinction is absurd.

The Court of Appeals explained its result as follows:

> "We may concede that in these respects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' 'own use.' Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of inpatients or emergency patients. The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer." 510 F.2d at 489.

This explanation merely restates the result.

Hospitals necessarily use drugs in treating inpatients and outpatients. The hospital's use of drugs in both cases is identical. In neither case does the hospital "consume" the drug. It is the patient—inpatient or outpatient—who does so. In both cases the hospital purchases the drug for resale to the patient. And in both cases the hospital is engaging in a "proper hospital function," as the Court of Appeals conceded. By what logic, then, can the Section 13c exemption be accorded to drugs used to treat inpatients but denied to drugs used to treat outpatients?

The decision confers the Section 13c exemption upon drugs used in the emergency clinic but denies the exemption to drugs used in the outpatient clinic. Yet study after study has shown that, in most urban hospitals, the emergency clinic doubles for all practical purposes as an outpatient clinic.[1] On what rational basis, then, can it be determined that drugs provided to patients in the emergency clinic are for the hospital's "own use," whereas drugs provided to patients in a hospital outpatient clinic are not?

The rigid lines drawn between inpatients and outpatients, between emergency clinics and outpatient clinics, and between other exempt and nonexempt categories are nowhere explained in the decision. They are, in fact, inexplicable.

IV.

The Decision Would Adversely Affect Nonprofit Hospitals—the Intended Beneficiaries of Section 13c—and the General Public.

A. *Compliance With the Decision Would Be Burdensome*

Section 13c was intended to confer substantial benefits upon hospitals and other nonprofit institutions. The decision of the Court of Appeals, however, would convert Section 13c benefits into burdens of considerable consequence.

How would a hospital attempt to comply with the decision? We see only four possibilities, all of them objectionable:

(1) A hospital could set up and maintain dual inventories and distribution systems for drugs and other hos-

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[1] Bodenheimer, *Patterns of American Ambulatory Care*, VII INQUIRY, Sept., 1970, at 26, 33; Perkoff and Anderson, *Relationship between Demographic Characteristics, Patient's Chief Complaint, and Medical Care Destination in an Emergency Room*, VIII MED. CARE 309 (1970) and studies cited therein.

pital supplies, one for "their own use" uses, within the meaning of the Court of Appeals decision, and the other for other proper hospital uses. The substantial costs and burdens of a double inventory system are obvious. It would require duplication of all supply functions and procedures—requisitions, bidding processes, purchase orders, accounting records, inventory, storeroom space, personnel and so on—for the thousands of different drugs and dosage forms typically stocked by a hospital pharmacy and for the many other supplies which hospitals purchase. The burden would be even greater in the large hospital which operates a number of satellite pharmacies within the hospital in order to distribute drugs more effectively.

(2) Alternatively, a hospital might be obligated to trace the uses to which a single inventory of hospital pharmaceuticals or other supplies are put, subsequently securing a rebate for items allocated to "for their own use" uses, or paying a surcharge for items allocated to other proper purposes. This arrangement, however, would be a formidable administrative task. Keeping track of the use to which all hospital supplies are put would be an extraordinary undertaking in view of the quantity of drugs and other supplies stocked by the hospital. Moreover, hospitals obtain their supplies from a variety of sources—manufacturers, wholesalers, distributors, jobbers and the like. Also, it is common for hospitals to purchase a single product from more than one supplier. It would be an extraordinary chore to determine which supplier owes a rebate to the hospital or is due a surcharge from the hospital.

(3) A hospital could simply pay higher prices for *all* of its prescription drugs and other supplies. This alternative would considerably increase the cost of hospital

operations, which are already high, and inevitably result in higher hospital bills to hospital patients and the public.

The taxpayers of this country already pay considerable sums of money to finance the cost of drugs dispensed through nonprofit hospitals. In fiscal year 1972-73, the Federal Government and the state governments spent $670 million for the drugs and drug sundries provided in connection with national health programs.[1] This amount would rise significantly if the Section 13c exemption were limited in the fashion prescribed by the Court of Appeals.

(4) Finally, a hospital might, at least in theory, eliminate its "nonexempt" functions, *e.g.,* its outpatient clinic and ambulatory care services. As we have already demonstrated, however, such services need to be expanded, not scuttled.

The decision of the Court of Appeals, if allowed to stand, would thus confront nonprofit hospitals with a series of extraordinarily onerous and unacceptable alternatives.

B. *Compliance With the Decision Would Be Costly*

No matter which course the hospital and its suppliers might take as a result of the decision below, the impact upon the public would be the same: higher hospital costs. The cost of hospital care will inevitably rise if hospitals must maintain double inventories, or pay higher prices for their supplies, or incur needless additional administrative expenses, or lose Section 13c prices entirely.

The Government, and ultimately, the taxpayer, would be obliged to pay more for hospital care. Medicaid costs, which cover outpatient prescription costs, would increase.

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[1] 37 Soc. Sec. Bull. No. 2, Table 2, p. 7 (February 1974).

The Government cost of financing various health programs administered by nonprofit hospitals—such as the migrant health program, 42 U.S.C. § 242h (Supp. III, 1973), and the Indian health program, 42 U.S.C. § 2002 (1970)—would also increase. Should Medicare be extended to cover outpatient prescriptions, the cost of that program would increase as well.

C. *The Decision Would Discourage Section 13c Prices for Any Supplies*

Even more distressing is the prospect that drug manufacturers and other hospital suppliers might feel compelled by the decision to discontinue all Section 13c special low prices. They might be unwilling to police their customers' distribution practices, or bear any risk of Robinson-Patman Act exposure. Should suppliers take this course, hospital expenses would soar, with consequent cost increases to those in need of medical care. All government medical assistance programs would suffer substantial cost increments across the board. And, of course, the purpose of the Section 13c exemption would be totally frustrated.

D. *The Decision Would Constrain the Development of Necessary Health Care Services*

The decision would frustrate the beneficent purposes of the Section 13c exemption in still another way—by denying hospitals the flexibility they require to respond to the needs of the communities they serve.

The categorical approach of the Court of Appeals is inappropriate and unworkable. The opinion does not merely determine the applicability of the Section 13c exemption to a particular drug sale, or a particular hospital, in particular factual circumstances. Instead, the decision attempts to identify every type of drug use by hospitals,

and to grant or deny the Section 13c exemption to each identified type of use in absolute, categorical fashion. The Section 13c exemption is simply not susceptible to this cubbyhole mode of analysis.

First, the eight categories of drug use listed in the Court of Appeals decision are insufficient to cover even the present range of hospital drug usage.[1] As hospitals continue to evolve, and as new modes of treatment are developed, it is inevitable that additional drug uses—not covered by the eight category analysis—will appear.

Second, the categories would impose arbitrary limits upon the application of the Section 13c exemption. Thus,

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[1] For example, the following common hospital uses do not fall within any of the eight categories considered by the Court of Appeals:

Example No. 1—drugs given to psychiatric inpatients released "on pass." Such inpatients are encouraged to spend weekends with family, but they must maintain their prescribed medication routine while out of the hospital;

Example No. 2—drugs administered to outpatients in the course of treatment at the clinic, on a one-time-only basis. For example, a physician at the clinic may administer an initial dose of penicillin to an outpatient by injection, and prescribe follow-up oral medication to be taken at home;

Example No. 3—drugs provided to outpatients for administration *in the hospital.* Oftentimes, such drugs, though available in neighborhood pharmacies, require special administration by a professional or require observation of the patient by a professional to guard against untoward reactions;

Example No. 4—drugs administered or dispensed to outpatients in the course of home treatment *by hospital physicians and staff.* As an extension of its inpatient and outpatient care services, an increasing number of hospitals administer home-care programs whereby professional staff of the hospital treat patients in the patients' own homes; and

Example No. 5—drugs provided to patients of affiliated extended care institutions where, by agreement, the hospital is responsible for certain aspects of patient care.

one category would disallow Section 13c benefits on sales to walk-ins—without regard to whether the sale is at noon on a business day or at midnight on a holiday weekend. Another category would disallow Section 13c benefits to all outpatients, whether or not the medication they require is even available in commercial pharmacies.

Respondents have argued that the Court of Appeals decision would not bar hospitals from providing drugs to the departing inpatient, the outpatient, the walk-in, or others in the non-exempt categories. But the Hobson's choices imposed by the Ninth Circuit decision may well constrain hospitals from providing services to those categories of patients.

Hospitals which presently lack ambulatory or outpatient facilities might simply decide not to open them. Other hospitals, anxious to avoid duplicate inventories and bookkeeping, might simply decide to discontinue take-home prescriptions or sales to walk-ins.

Surely the Congress did not intend that Section 13c serve to burden, rather than benefit, nonprofit institutions. Nor did the Congress intend that Section 13c deter any nonprofit institution from performing anything less than the maximum amount of public service.

The decision of the Court of Appeals would frustrate rather than further the purpose of the Nonprofit Institutions Act. It should be reversed.

V.

The Proper Section 13c Test Is Whether the Primary Purpose of the Hospital's Purchase of Supplies Is the Treatment of Its Patients or the Performance of Other Legitimate Hospital Functions.

The deficiencies in the Court of Appeals opinion will not be cured by moving the line separating "exempt" and "non-exempt" categories, or by adding additional categories of drug use. The fundamental flaw in the decision is its cubby-hole approach. The scope of the Section 13c exemption should be determined in entirely different fashion.

The controlling question should be the *primary purpose* of the purchase by the hospital: is it for the treatment of hospital patients or the performance of other legitimate hospital functions? If so, we submit, the Section 13c exemption should apply.

This functional approach to Section 13c was utilized, ironically, by the Ninth Circuit in *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967). In that case, the court considered whether the sale of bowling lanes and equipment to the Utah State University by Brunswick at lower prices than it charged plaintiff for similar equipment constituted a violation of the Robinson-Patman Act. Plaintiff contended that the Section 13c exemption was inapplicable. It argued that because the student bowling alleys were open to and used by the public, the purchase of the bowling lanes was not for the University's "own use."

The Court of Appeals emphatically rejected that argument:

> *"The primary purpose of the purchases* established beyond dispute, was to fulfill the needs of the University in providing bowling facilities for its students, faculty and staff. This being the case, any additional use of the bowling facilities by the general public for a fee, even if such use is substantial, would not establish that the purchases were not made for the use of the University."[1]

The primary purpose test is eminently sensible and should be endorsed by this Court:

First, the primary purpose test fulfills the intent of Congress. Section 13c was intended to benefit nonprofit institutions by enabling them "to operate as inexpensively as possible."[2] As we have demonstrated, however, the Ninth Circuit's categorical test would transform benefits into burdens. The primary purpose test would accord nonprofit institutions the price benefits Congress intended to confer without shackling their ability to fulfill their institutional purposes.

Second, the primary purpose test would not oblige the judiciary to decide what functions a hospital—or a church or school or library—should or should not perform. The court in *Logan Lanes* accepted without challenge the university's decision to provide bowling facilities for its students, faculty and staff. The court did not try to second-guess the institution's own determination of what functions it should serve, or what supplies it should purchase—for its "own use"—to fulfill those functions.

Third, the primary purpose test would make it unnecessary for the judiciary to attempt the impossible, that is,

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[1] 378 F.2d at 217 (emphasis supplied).

[2] *Id.* at 216.

the identification and quantification of every use to which every school, library, church and hospital purchase is put. Once it was established in *Logan Lanes* that the "primary purpose" of the purchases was to "fulfill the needs" of the institution, the court ruled as a matter of law that the purchases were for the institution's "own use," without inquiring further into what collateral uses may have been made of the purchased supplies.[1]

By contrast, the decision below would apparently require judicial scrutiny of all uses of all supplies purchased by nonprofit institutions. The categorical test would compel courts to separate out (1) uses for proper institutional purposes and (2) uses "for their own use"; only the latter would be entitled to the Section 13c exemption.

The application of the primary purpose test would put an end to the illusory distinction between purchases for a hospital's "proper function" and a hospital's "own use." It would provide a sensible result in the instant case, and a workable foundation for subsequent interpretations of Section 13c. And it would best effectuate Congress' intent in granting a Robinson-Patman exemption to nonprofit institutions.

For these reasons, we urge the Court to reject any categorical test and to adopt the primary purpose test employed in *Logan Lanes.*

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[1] The Internal Revenue Service has adopted a similarly sensible test for determining whether a hospital is engaging in an unrelated business through its sale of drugs to various persons. The IRS test is whether the drugs are sold to *patients* of the hospital. In-patients, outpatients, discharged patients, patients receiving medical services as part of a home care program or in an extended care facility—all have been deemed to be "patients" of the hospital. See Rev. Rul. 68-376, 1968-2 CUM. BULL. 246, reproduced in Appendix 2, *infra.*

VI.

The "Primary Purpose" Test Would Accord the Section 13c Exemption to the Drug Purchases in Issue.

The record shows that the drugs in issue in this case were purchased primarily for the treatment of hospital inpatients and outpatients. During the most recent twelve month period for which there is evidence in the record, over 97% of all drug sales by nine Portland hospitals were made to inpatients and outpatients.[1] Since the drugs were purchased primarily for the purpose of treating hospital patients, we submit that all such drug purchases are covered by the Section 13c exemption.

Drug therapy is unquestionably an integral part of medical care:

> "The development of medical care in the last several decades is, in part attributable to the development and distribution of new drugs and medicines. The advent of the miracle drugs, such as antibiotics, tranquilizers, analgesics, and other new therapeutic substances, has increased the length of life, reduced communicable disease, eased the burdens of chronic disease and mental illness, and relieved much pain and discomfort. At the same time, the pharmaceutical armamentarium that has become available reduces the total cost and time of treatment for many illnesses."[2]

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[1] See Tr. 5/25/73 at 16-17.

[2] DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, INCLUSION OF PHARMACEUTICAL SERVICES IN HEALTH MAINTENANCE AND RELATED ORGANIZATIONS, DHEW Publication No. (HSA) 74-13017, at 4 (1974).

Thus, the sale of drugs is an "inseparable component of the *service* provided by" a hospital.[1]

The dispensing of drugs to departing inpatients, outpatients and other sick people is no less a component of the therapeutic service provided by a hospital than the dispensing of drugs to inpatients. As one authority has observed:

> "If we believe that the pharmacist should be in the inpatient care area and contribute his knowledge to improved standards of care, should not ambulant patients receive the same benefit from the pharmacist's services? A double standard of care cannot be condoned."[2]

Admittedly, hospitals dispense drugs to inpatients and emergency room patients of necessity. Alternative sources of supply are unavailable to the bedridden. But this distinction provides no basis on which to condition the application of the Section 13c exemption.[3] The controlling fact is that drugs are dispensed to departing inpatients, outpatients, and other sick people for the very same pur-

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[1] *Hospital Building Co.* v. *Trustees of Rex Hospital*, 511 F.2d 678, 683 (4th Cir. 1975), *petition for cert. filed*, 43 U.S.L.W. 3626 (U.S. May 19, 1975) (No. 74-1452).

[2] Brodie & Graber, *Institutional Pharmacy Practice in the 1970's*, 28 AM. J. HOSP. PHARMACY 240, 244 (1971).

[3] The Robinson-Patman Act only prohibits price discriminations which cause competitive injury. F. ROWE, PRICE-DISCRIMINATION UNDER THE ROBINSON-PATMAN ACT 19 (1962). Congress would have had no reason to enact the Nonprofit Institutions Act if the scope of the Section 13c exemption was to be limited to instances in which the nonprofit institution is not in competition with any other institution.

pose that they are dispensed to inpatients and emergency room patients—to make them well.[1]

There are special reasons why hospitals should dispense drugs to outpatients. Hospital dispensing encourages patient compliance with the medication regimen. Studies have disclosed a significant incidence of patient noncompliance with drug therapy routines.[2]

> "In our present health care system primary emphasis is placed on diagnosis and then the prescribing of a certain course of therapy for the patients. What happens from this point on has largely been a matter of chance. Whether the prescription is ever filled, whether the patient takes the medication as directed, or whether

[1] The Internal Revenue Service has looked to the therapeutic rationale for various hospital operations to determine whether they constitute unrelated businesses. In ruling on the tax exempt status of hospital parking lots, the IRS concluded:

> "One of the purposes of the hospital is to provide health care for members of the community. Visitation of patients constitutes supportive therapy that assists in patient treatment and encourages their recovery. Without adequate parking facilities for patients and visitors, the hospital could not operate with maximum effectiveness in serving the public." Rev. Rul. 69-269, 1969-1 CUM. BULL. 160, 161.

In addition, the IRS has considered whether such operations will increase the efficiency of the hospital. Thus, "the sale of . . . personal effects by the gift shop to hospital personnel" was held to contribute importantly to the hospital's exempt purpose because "it is to the hospital's advantage to keep its employees and medical staff on its premises throughout their working days." Rev. Rul. 69-267, 1969-1, CUM. BULL. 160. This same reasoning would find the sale of pharmaceutical supplies to hospital staff and employees to be within the scope of the Section 13c exemption, even without regard to the primary purpose test. *See also,* Rev. Rul. 69-268, 1969-1 CUM. BULL. 160.

[2] *See* Sharpe & Mikeal, *Patient compliance with antibiotic regimens,* 31 AM. J. HOSP. PHARMACY 479 (1974); Marston, *Compliance With Medical Regimens: A Review of the Literature,* 19 NURSING RESEARCH 312 (1970).

> he is also taking other medication that may interact, has been open to speculation."[1]

Obviously, the probability that a patient will obtain and take his prescribed medicine is increased if a pharmacy is located in the outpatient clinic. In addition, the prospect of errors in the administration of the medication is minimized if instructions are provided by the dispensing pharmacist.[2] Studies have confirmed that patient-pharmacist counseling "is an effective means for improving patient compliance and understanding of the medication regimen."[3]

In sum, the drugs in issue here were purchased primarily for the purpose of treating hospital patients, outpatients as well as inpatients. This is a proper hospital purpose. Accordingly, all of the drug purchases in issue are exempted from the provisions of the Robinson-Patman Act by Section 13c.

[1] Stewart & Cluff, *A review of medication errors and compliance in ambulant patients,* 13 CLINICAL PHARMACOLOGY AND THERAPEUTICS 463, 465 (1972).

[2] "Patients should receive more complete instructions concerning the proper use of medication. In our society, better instructions are provided when purchasing a new camera or automobile than when the patient receives a lifesaving antibiotic or cardiac drug. The hospital provides an excellent setting for teaching patients about the use of prescription and nonprescription drugs." *Id.* at 467.

[3] Madden, *Evaluation of Outpatient Pharmacy Patient Counselling,* NS13 J. AM. PHARMACEUTICAL ASS'N 437, 442 (1973).

CONCLUSION

For the foregoing reasons, *amicus curiae* respectfully urges that this Court reverse the decision of the Court of Appeals and reinstate the decision of the District Court.

Respectfully submitted,

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APPENDIX

APPENDIX 1*

Figure 1-1. Cause of the Increase in Ambulatory Visits to Hospitals

Demographic, social, and economic shifts

1. Population increase of about 2 percent per annum
2. Aging of the population
3. Increasing prevalence of chronic diseases
4. Rise in accident rates
5. Large concentrations of low income groups in metropolitan areas with few physicians
6. Inability to afford private medical care
7. High level of geographic mobility with substantial numbers of patients without a regular family doctor
8. Increase in numbers of persons who visit a hospital outpatient facility for minor conditions previously treated at home

Reduced availability and accessibility of primary care

1. Decrease in the number of general practitioners who function as the primary care physician of first contact
2. Private physicians dying or leaving inner-city areas to relocate elsewhere and not being replaced

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* Reprinted from Piore, ***Problems and Opportunities for Community Hospitals in Primary Care,*** CENTER FOR COMMUNITY HEALTH SYSTEMS, COLUMBIA UNIVERSITY, COMMUNITY HOSPITALS AND THE CHALLENGE OF PRIMARY CARE 18-19 (1975).

3. Increasing unavailability of physicians at night or on weekends or holidays
4. Reluctance of physicians to make house calls
5. Unwillingness of patients to inconvenience private physicians outside of office hours
6. Increasing physician specialization, accompanied by patient's confusion about which specialist to call, arrangement of office hours by appointment only, physician's unwillingness to accept responsibility for a patient's problem outside his field of interest
7. Decrease in independent capacity of the physician to treat emergency conditions optimally in his office, as a consequence of the increase in medical science and technology

Institutionalization of medical care in hospitals

1. Historical change in role of hospital from last resort of the dying, to the workshop of the physician for all serious illness, then to the function of community health center
2. Availability in hospital of complex and costly equipment operated by highly skilled personnel
3. Physician's acceptance of hospital emergency facility, in preference to his office, as a place of treatment of injuries, acute illnesses, and even some non-acute conditions
4. Increased public awareness of the hospital as an appropriate place to seek care and greater confidence in its outpatient facilities

5. Informal, non-appointment, casual medical care relinquished to hospital
6. Availability of round-the-clock medical care, which hospital may be legally required to provide
7. Accessibility of hospitals to the highly concentrated urban population

Changes in insurance plans and public attitudes

1. Extension of benefits by many health insurance plans to services rendered in emergency departments but not to those rendered in office visits or house calls
2. Growing tendency for industries, schools, and police to refer patients to the emergency facility
3. People's increasing sophistication in identifying symptoms and perceiving the immediacy with which they should be treated by a physician
4. Absence of effective screening at the various entry points to the emergency medical system, with the result that many non-urgent patients are entering the system

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Source: Adapted from M. L. Webb, "The Emergency Medical Care System in a Metropolitan Area," Department of Public Health Thesis, School of Hygiene and Public Health, Johns Hopkins University, 1969.

APPENDIX 2

REV. RULING 68-376, 1968-2 CUM. BULL. 246

The Internal Revenue Service has been requested to set forth situations in which persons who purchase pharmaceutical supplies from the pharmacy of a hospital exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954 are considered "patients" of the hospital within the meaning of section 513 (a)(2) of the Code.

Section 513 of the Code defines the term "unrelated trade or business" as any trade or business the conduct of which is not substantially related (aside from the need of an organization for income or funds or the use it makes of the profits derived) to the exercise or performance by an organization of its exempt functions. However, to the extent relevant here, section 513(a)(2) of the Code further states that such term does not include any trade or business which is carried on by an organization described in section 501(c)(3) primarily for the convenience of its patients.

In the case of a hospital exempt under section 501(c)(3) of the Code, the sale of pharmaceutical supplies by its pharmacy to persons considered "patients" of the hospital does not constitute unrelated trade or business as defined in section 513 of the Code. See section 1.513-1(c)(2)(ii) of the Income Tax Regulations. Depending upon his relationship with the hospital, a purchaser of pharmaceutical supplies from the pharmacy of a hospital exempt from Federal income tax under section 501(c)(3) of the Code may be considered a "patient" of the hospital as that term is used in section 513(a)(2) of the Code.

Examples of relationships that determine whether a person is a "patient" of a hospital for purposes of section 513(a)(2) of the Code are illustrated in the six situations set out below.

Situation 1—A person admitted to a hospital as an inpatient.

A is admitted to the hospital as an inpatient. He receives bed, meals, diagnostic services, and treatment for his illness. He is a "patient" of the hospital.

Situation 2—A person receiving general or emergency diagnostic, therapeutic, or preventive health services from outpatient facilities of a hospital.

B is taken to the hospital's emergency room for treatment of injuries sustained in an accident. He is treated in the emergency room and discharged, but is told to return to the hospital's outpatient clinic for further treatment. The hospital maintains an outpatient clinic having regularly scheduled hours during which medical services are provided on an outpatient basis. The governing authority of the hospital has full legal responsibility for the conduct of the clinic. *B* visits the clinic, is registered as a patient, and receives medical care. Treatment in either the emergency room or the outpatient clinic is sufficient to make *B* a "patient" of the hospital.

Situation 3—A person directly referred to the hospital's outpatient facilities by his private physician for specific diagnostic or treatment procedures.

C's private physician refers him to the hospital's outpatient diagnostic facilities for a specific diagnostic pro-

cedure. The procedure is administered by a hospital-based practitioner affiliated with the hospital. The availability of these diagnostic procedures is an integral part of the services offered by the hospital. *C* is a "patient" of the hospital.

Situation 4—A person refilling a prescription written during the course of his treatment as a patient of the hospital.

D was formerly a patient of the hospital. During his course of treatment the attending staff physician gave *D* a prescription. *D* filled the prescription at the hospital pharmacy, which filed and retained it. After formal discharge as a patient, he finds it convenient to return to the hospital pharmacy to obtain a refill of that prescription. Since the prescription was written in the course of the hospital-patient relationship, *D* is a "patient" of the hospital.

Situation 5—A person receiving medical services as part of a hospital administered home care program.

E receives medical services in his residence. The services are rendered by, and under the supervision of, the professional staff of the hospital as an extension of its inpatient and outpatient care. *E* is a "patient" of the hospital.

Situation 6—A person receiving medical care and services in a hospital-affiliated extended care facility.

F is a patient in an extended care facility qualified to participate in Medicare and other government financed programs. The facility is affiliated with the hospital which,

by agreement, is responsible for certain of its professional activities, especially those necessary to qualify the facility for participating in the Medicare program. While a patient in the facility, *F* is under the medical supervision of a member of the hospital's medical staff and thus is a "patient" of the hospital.

Accordingly, sales of pharmaceutical supplies to the "patients" in each of the situations described do not constitute unrelated trade or business of the hospital within the meaning of section 513 of the Code.

See Revenue Rulings 68-374 and 68-375, pages 242 and 245 of this Bulletin, for other situations involving sales of pharmaceutical supplies by pharmacies operated by hospitals.

Supreme Court, U. S.
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In the Supreme Court

of the United States

OCTOBER TERM, 1975

No. 74-1274

ABBOTT LABORATORIES, *et al.*,
Petitioners,

-v.-

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.
Respondent

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF FOR ALABAMA PHARMACEUTICAL ASSOCIATION FLORIDA PHARMACEUTICAL ASSOCIATION GEORGIA PHARMACEUTICAL ASSOCIATION KENTUCKY PHARMACEUTICAL ASSOCIATION MISSISSIPPI PHARMACEUTICAL ASSOCIATION NORTH CAROLINA PHARMACEUTICAL ASSOCIATION SOUTH CAROLINA PHARMACEUTICAL ASSOCIATION TENNESSEE PHARMACEUTICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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In the Supreme Court
of the United States

OCTOBER TERM, 1975

No. 74-1274

ABBOTT LABORATORIES, *et. al.*,
Petitioners,

-V.-

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.
Respondent

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH DISTRICT

MOTION OF THE ALABAMA PHARMACEUTICAL ASSOCIATION, FLORIDA PHARMACEUTICAL ASSOCIATION, GEORGIA PHARMACEUTICAL ASSOCIATION, KENTUCKY PHARMACEUTICAL ASSOCIATION, MISSISSIPPI PHARMACEUTICAL ASSOCIATION, NORTH CAROLINA PHARMACEUTICAL ASSOCIATION, SOUTH CAROLINA PHARMACEUTICAL ASSOCIATION AND TENNESSEE PHARMACEUTICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE*

Pursuant to Rule 42 of the Rules of this Court, the Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee Pharmaceutical Associations hereby respectfully move this Court for leave to file the attached brief *amicus curiae* in the above-captioned case.

The brief urges the Court to affirm the decision of the Court of Appeals for the Ninth Circuit in the above entitled case.

Counsel for the respondent has consented to the filing of the attached brief. Counsel for the petitioners have not consented to its filing.

The Interest of the Pharmaceutical Associations of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

The Pharmaceutical Associations of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee (referred to hereafter as "the associations") are the professional organizations representing the individual pharmacists in these respective eight states. The general purposes of these eight professional pharmaceutical associations are to promote the public welfare through the profession of pharmacy and to represent the interest of the individual pharmacists within these eight states.

It is in the furtherance of the above-stated purposes that these eight state pharmaceutical associations wish to express to this Court their views as to the significance of the decision of the Court of Appeals for the Ninth Circuit and to urge the affirmance of that decision.

The decision of the Court of Appeals has

massive precedential consequences to retail pharmacy in all eight of the above-mentioned states. A decision contrary to that of the Court of Appeals would threaten the existence of community retail pharmacy in all eight states.

The associations contend that the holding of the Court of Appeals in this case is the only logical interpretation of the Nonprofit Institutions Act and the Robinson-Patman Act consistent with the general purpose of both statutes. The construction of the Nonprofit Institutions Act urged by petitioners in the Ninth Circuit Court of Appeals would result in a circumvention of the purpose of both this statute and the Robinson-Patman Act, thus creating potential for a monopolistic climate which could destroy community retail pharmacy.

The Nonprofit Institutions Act was enacted to confer benefits upon nonprofit institutions such as nonprofit hospitals in an area where the nonprofit hospital operates on a different functional level than retail pharmacy. A non-profit hospital providing medication to patients admitted to the institution, either as bed patients (patients occupying room and board facilities within the institution) or as emergency room patients, is not on a competitive or functional level with retail pharmacy. A nonprofit hospital engaging in the resale of medication to members of the general public, not admitted to the institution as bed patients or emergency room patients, assumes a competitive and

functional level with that of retail pharmacy.

The ultimate result of a decision allowing nonprofit hospitals to compete on the functional level of retail pharmacy without the restrictions of the Robinson-Patman Act of 1936 would destroy the retail pharmacy segment of local business. It would destroy retail pharmacy because it would allow and encourage nonprofit hospitals to resell pharmaceuticals to the general public in competition with retail pharmacy at a price often below the acquisition cost of retail pharmacies. The simple economics of such a business climate would result in the closing of retail pharmacies and the monopolizing of pharmacy by nonprofit hospitals. Such a result would adversely affect the delivery of health care services at the community level.

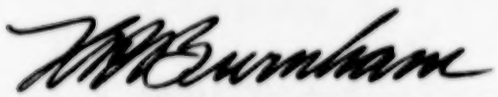
There are, within each of the eight states listed in this petition, nonprofit hospitals that purchase supplies from the petitioners. The question of whether these nonprofit hospitals may utilize the Nonprofit Institutions Act to purchase drugs for resale and operate on the same functional level as retail pharmacy in the resale of these drugs is of paramount importance to the pharmacies of these eight states. It is this "functional level" test which the associations would urge the Court to apply in affirming the Court of Appeals' decision.

In view of the tremendous impact on pharmacy in these eight states that a reversal of the Ninth Circuit Court of Appeals would have, surely it is appropriate that the

pharmacists of these eight states be given the opportunity to convey to the Court their view of the application of this exemption to the Robinson-Patman Act as it affects their profession.

Accordingly, the Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee Pharmaceutical Associations respectfully urge this Court to grant their motion for leave to file this brief as *amicus curiae*.

Respectfully submitted,



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Interest of *Amicus Curiae*

The interest of Alabama Pharmaceutical Association, Florida Pharmaceutical Association, Georgia Pharmaceutical Association, Kentucky Pharmaceutical Association, Mississippi Pharmaceutical Association, North Carolina Pharmaceutical Association, South Carolina Pharmaceutical Association, and Tennessee Pharmaceutical Association as *amicus curiae* is set forth in the preceding motion for leave to file this brief.

Question Presented

Is the Nonprofit Institutions Act exemption to the Robinson-Patman Act of 1936 applicable to the purchase of drugs by a nonprofit hospital for resale to patients not admitted to the hospital as inpatients or as patients in the emergency clinic?

Statutes Involved

1. Section 1 of the Robinson-Patman Act, 49 Stat. 1526, 15 U.S.C. § 13(a):

> "(a) It shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality, where either or any of the purchases involved in such discrimination are in commerce, where such commodities are sold for use, consumption, or resale within the United States or any Territory thereof

> or the District of Columbia or any insular possession or other place under the jurisdiction of the United States, and where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them. . . ."

2. The Nonprofit Institutions Act, 52 Stat. 446, 15 U.S.C. § 13c:

> "Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."

Statement of the Case

1. Proceedings in the Lower Courts

Respondent filed this action for treble damages and injunctive relief as the assignee of claims for sixty retail pharmacies doing business in metropolitan Portland, Oregon, charging petitioners, twelve drug manufacturers, with violation of the Robinson-Patman Act, 15 U.S.C. §§ 13 *et seq.* (1970). Respondent alleged that petitioners engaged in unlawful price discrimination by selling drugs to nonprofit hospitals at prices lower

than those offered to retail pharmacies.

Petitioners filed a motion for summary judgment on the respondent's claim stating as ground for the motion for summary judgment that the Nonprofit Institutions Act, 15 U.S.C. § 13c (1970) excepts the purchases of drugs by nonprofit hospitals from the Robinson-Patman Act. On May 25, 1973, the district court granted the motion of the petitioners. (Tr. 5/25/73 at 88-99.)

The Court of Appeals for the Ninth Circuit disagreed with the district court and vacated the judgment of the district court and remanded the case for further proceedings. 510 F. 2d 486. Petitioners filed a petition for rehearing which was denied on March 11, 1975. On June 23, 1975, petition for certiorari was granted by this Court.

2. Court of Appeals Decision

The Court of Appeals vacated the judgment of the district court because it interpreted the Nonprofit Institutions Act to exempt a hospital's "own use" of drugs under the statute to include only drugs administered to inpatients and to patients in the emergency room. In holding that drugs dispensed to registered hospital patients who are treated as outpatients, to inpatients as take-home drugs, and to hospital employees and staff physicians for personal and family consumption, the Court of Appeals summarized its views as:

"We may concede that in these re-

spects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' 'own use.' Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of in-patients or emergency patients. The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer." [1]

Summary of Argument

In 1936 Congress enacted the Robinson-Patman Act to protect small business against discriminatory price practices of large interstate businesses.[2] The Nonprofit Institutions Act of 1938 was enacted as an exemption from the Robinson-Patman Act for nonprofit institutions in the purchase of supplies for their own use.

The issue before the Court in this case is

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1. *The Portland Retail Druggists Association, Inc. v. Abbott Laboratories, et al.*, 510 F. 2d 486, 489 (9th Circuit 1974).

2. *Federal Trade Commission v. Anheuser-Busch Inc.*, 363 U.S. 536 (1960).

whether or not large nonprofit institutions may invoke the Nonprofit Institutions Act exemption to purchase supplies "for resale" to the general public rather than for their "own use" within the institutions.

The Robinson-Patman Act of 1936 was enacted to assure that businesses operating on a competitive functional level would be on an equal basis as far as price is concerned.[3] Congress intended to eliminate price discrimination practices threatening independent merchants.

Nonprofit hospitals engaging in the sale of pharmaceuticals to patients not admitted in the emergency room temporarily or as bed patients (patients occupying room and board facilities within the institution) of the hospital are on the same functional level as retail pharmacy. When a nonprofit hospital chooses to operate on the same functional level as retail pharmacies, they are not entitled to purchase these "supplies" for resale under the Nonprofit Institutions Act exemption to the Robinson-Patman Act.

The Nonprofit Institutions Act of 1938 was enacted to allow nonprofit institutions to acquire their supplies as inexpensively as possible. This exemption was not intended for the purchase of "supplies" for resale to the general public, but rather for the institutions' own use. The Ninth Circuit Court of Appeals held, as a matter of law, that a hospital's "own use" of drugs under the statute includes only drugs administered to inpatients and to patients in the emergency room. This is the only logical construction of this exemption to the Robinson-Patman Act which will not result in the use of interstate business to destroy local business.

If a nonprofit hospital chooses to operate on the same functional level as retail pharmacy in the resale of drugs, it must relinquish its exemption from the Robinson-Patman Act as to those drugs purchased for resale to the general public in competition with community retail pharmacy.

ARGUMENT

Introduction

The Robinson-Patman Antidiscrimination Act was enacted by Congress in 1936 to protect small businesses against favoritism shown by suppliers to large buyers.[4] It provides in part that:

> "It shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality, . . . where such

3. *Federal Trade Commission v. Sun Oil Company*, 371 U.S. 505 (1963).

4. *Federal Trade Commission v. Anheuser-Busch Inc.*, 363 U.S. 536 (1960); *Federal Trade Commission v. Sun Oil Company*, 371 U.S. 505 (1963).

commodities are sold for use, consumption, or resale within the United States . . . , and where the effect of such discrimination may be substantially to lessen competition . . ."[5]

Two years later, in 1938, the Nonprofit Institutions Act was enacted as an exemption from the prohibitions of the Robinson-Patman Act for nonprofit institutions in the purchase of supplies for their own use. The Nonprofit Institutions Act provides:

"Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."[6]

The instant question before the Court is whether or not the Nonprofit Institutions Act can be used to circumvent the purpose of the Robinson-Patman Act by allowing large nonprofit institutions to invoke this exemption to purchase supplies "for resale" to the general public rather than for their "own use" within the institutions. This particular circumvention of the purpose of the Robinson-Patman Act would threaten the survival

5. Section 1 of the Robinson-Patman Act, 49 Stat. 1526, 15 U.S.C. §13(a).

6. The Nonprofit Institutions Act, 52 Stat. 446, 15 U.S.C. §13c.

of smaller local merchants (retail pharmacy), the protection of which is the very purpose of the Robinson-Patman Act.

The Court of Appeals drew a distinction between consumption of drugs within the institutions with that of consumption of drugs outside the institutions. This distinction succinctly adheres to the purpose of both the Robinson-Patman Act and the Nonprofit Institutions Act. The administration of medications to bed and emergency care patients within the institutions is by its very nature a function of the institutions in their "own use" of the medication in the treatment of their patients. These acts are not in competition with retail pharmacy and are the singular source of the medication to the patient. It is equally clear that the dispensing of medication to inpatients at the time of discharge, to hospital outpatients, to employees of the hospital and to staff doctors for personal and family use are resales to the general public in competition with retail pharmacy and violative of the Robinson-Patman Act.

I.

The Robinson-Patman Act of 1936 was enacted to assure that businesses at the same functional level would start on an equal competitive footing as far as price is concerned. [7]

7. *Federal Trade Commission v. Sun Oil Company*, 371 U.S. 505 (1963).

The Robinson-Patman Act of June 19, 1936 was enacted as a protection for small businesses which are unable to buy in quantities against competing operations of large interstate concerns.[8] Price favoritism shown by suppliers to large buyers caused congressional concern for the survival of smaller local merchants, and the 1936 Robinson-Patman amendments to the Clayton Act were passed to strengthen the Clayton Act prohibitions on price discrimination.[9] Thus the fundamental purpose of the Robinson-Patman Act is to protect the small independent businessman.

The Court's opinion explaining the basic purposes of the Robinson-Patman Act in *Federal Trade Commission v. Sun Oil*[10] expounds the position of retail pharmacy in this case. The Court stated that the basic purpose of the Act was to insure that purchasers from a single supplier would not be injured by that supplier's discriminatory practices. The Court noted that "Congress sought generally to obviate price discrimination practices threatening independent merchants and businessmen presumably from

8. *Federal Trade Commission v. Morton Salt Co.*, 334 U.S. 37 (1948); *Standard Oil Co. v. Federal Trade Commission*, 340 U.S. 231 (1951).

9. *Federal Trade Commission v. Anheuser Busch Inc.*, 363 U.S. 536 (1960); *Federal Trade Commission v. Sun Oil Company*, 371 U.S. 505 (1963).

10. 371 U.S. 505 (1963).

whatever source."[11] It is irrefutable that each of the petitioners is the single supplier of its "brand name" product and that retail pharmacies are members of that class of independent merchants and businessmen which the Robinson-Patman Act protects.

The question then must focus on the level of protection Congress intended for independent merchants and businessmen. *Federal Trade Commission v. Sun Oil Co.*, answers this query in the following language:

> "In short, Congress intended to assure, to the extent reasonably practicable, that businessmen at the same functional level would start on equal competitive footing so far as price is concerned."[12]

Hospitals dispensing pharmaceuticals to patients "admitted" to the hospital, whether temporarily in emergency room or as bed patients, are not on the same functional level as retail pharmacies. Hospitals engaging in the sale of pharmaceuticals to patients not admitted in the emergency room temporarily or as bed patients of the hospital are on the same functional level as retail pharmacy. This second category entails exactly the potentiality for price discrimination that Congress intended to alleviate with the Robinson-Patman Act. It is axiomatic that, when

11. *Federal Trade Commission v. Sun Oil Company*, 371 U.S. 505, 520 (1963).

12. 371 U.S. 505, 520 (1963).

nonprofit hospitals choose to operate on the same functional level as retail pharmacies, they must relinquish their exemption to the Robinson-Patman Act.

Unquestionably, the Robinson-Patman Act is directed against discriminatory treatment of purchasers engaged in the resale of the seller's goods.[13] Congressional intent was clearly demonstrated by the language used in the Nonprofit Institutions Act exemption limiting the exemption to purchases of supplies "FOR THEIR OWN USE."[14] The exemption extended was for "use" or "consumption" by the nonprofit institutions and not for the resale of the supplies. Hospital bed patients (patients occupying room and board facilities within the hospital) and emergency room patients have no discretion in selecting the provider of medication used to treat them and thus price discrimination is of no impact. As regards patients other than bed or emergency patients of the hospital, the patient may exercise discretion as to the provider of the medication and thus the purpose of the Robinson-Patman Act becomes of paramount consideration.

The unit dose administration of medication to patients consumed within the hospital

13. *Centex-Winston Corporation v. Edward Hines Lumber Co.*, 447 F. 2d 585 (7th Circuit 1971), cert. denied, 405 U.S. 921 (1972).

14. The Nonprofit Institutions Act, 52 Stat. 446, 15 U.S.C. §13c.

is "use" of supplies purchased by the hospital as contemplated by the Nonprofit Institutions Act exemption. Medication purchased by an individual which is administered or consumed outside the hospital, results in the resale of the "supplies" purchased by the nonprofit hospital and as a resale is a violation of the Robinson-Patman Act.

The Court of Appeals correctly distinguished between the purchases for uses which retailers cannot supply and which, therefore, can have no competitive impact on retailers and those purchases for resale by the hospital which retailers can supply.[15] Where the institutions' supplies are the single source available for the hospital's treatment of its patients, the Nonprofit Institutions Act is applicable. However, where the purchase is for resale by the hospital in competition with local retail pharmacies, the exemption from the Robinson-Patman Act is inapplicable.

II.

The Nonprofit Institutions Act of 1938 was enacted to allow inexpensive acquisition of supplies by nonprofit institutions for their own use—not for resale to the public.

15. *Ag-Chem Equipment Co., Inc. v. Hahn, Inc.*, 480 F 2d 482 (8th Circuit 1973); *Sano Petroleum Corporation v. American Oil Company*, 187 F Supp. 345 (E.D. New York 1960).

An examination of the statutory language used in the Nonprofit Institut ons Act readily reveals the restrictive phraseology employed by Congress to limit this exemption from the Robinson-Patman Act to the acquisition of supplies for the institutions' internal use. It can be fairly inferred that Congress did not intend to modify or change the purpose of the Robinson-Patman Act by the Nonprofit Institutions Act from the House Judiciary Committee's comment that "(t)he Committee does not feel that the wholesome purpose of the Robinson-Patman Act will be interfered with by the enactment of this bill . . ."[16] The construction applied by the Court of Appeals in this case is the only application of the Nonprofit Institutions Act exemption that would not interfere with the wholesome purpose of the Robinson-Patman Act.

The restrictive phrase, ". . . purchases of their supplies for their own use . . ."[17] is the focal point of the issues in this case. The question is whether a nonprofit hospital may acquire drugs for resale to a private consumer at an acquisition price that discriminates against local retail druggists. A private consumer being a consumer other than inpatients or emergency patients of the nonprofit hospital.

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16. *House Report* 2161, 7th Cong., 3d Sess., April 19, 1938.

17. The Nonprofit Institutions Act, 52 Stat. 446, 15 U.S.C. §13c.

The Court of Appeals held, as a matter of law, that a hospital's "own use" of drugs under the statute includes only drugs administered to inpatients and to patients in the emergency room.

A construction of the Nonprofit Institutions Act different from that applied by the Court of Appeals would encourage nonprofit hospitals to compete with retail pharmacy. The inevitable result of such competition would thwart the purpose of the Robinson-Patman Act and threaten the existence of retail pharmacy. In addition to destroying local business (retail pharmacy), a diminution in retail pharmacy would adversely affect the delivery of health care service at the community level.

It has consistently been adhered to by this Court that exceptions contained in statutes are to be construed strictly.[18] In *Moore v. Mead's Fine Bread Company, a Corp.*, Justice Douglas stated:

> "It is, we think, clear that Congress by the Clayton Act and Robinson-Patman Act barred the use of interstate business to destroy local business . . ."[19]

The construction by the Court of Appeals of this exception protects local business. The

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18. *United States v. Scharton*, 285 U.S. 518 (1932); *Great Atlantic & Pacific Tea Co. v. Federal Trade Commission*, 106 F 2d 667 (3rd Circuit 1939).

19. 348 U.S. 115, 121 (1954).

alternative construction proposed by petitioners will result in the use of interstate business to destroy local business.

In summary, when a nonprofit hospital purchases drugs for resale on a functional level with retail pharmacy, the purchase is not for its own use and is not exempt from the provisions of the Robinson-Patman Act by the Nonprofit Institutions Act.

CONCLUSION

For the foregoing reasons, *amicus curiae* respectfully urges that this Court affirm the decision of the Court of Appeals.

Respectfully submitted,

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IN THE

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v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., *Respondent*

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

JOINT BRIEF AMICUS CURIAE OF THE AMERICAN PHARMACEUTICAL ASSOCIATION AND THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

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JOINT BRIEF AMICUS CURIAE OF THE AMERICAN PHARMACEUTICAL ASSOCIATION AND THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

By consent of the petitioners and the respondent the American Pharmaceutical Association and the National Association of Retail Druggists file this brief as *amici curiae.*

PRELIMINARY STATEMENT

The American Pharmaceutical Association and the National Association of Retail Druggists file this joint brief amicus curiae, urging that the December 26, 1974 decision and order of the United States Court of Appeals for the Ninth Circuit be affirmed.

INTEREST OF THE AMICI

The American Pharmaceutical Association (APhA) is a nonprofit, membership corporation organized and existing under the laws of the District of Columbia since 1852. It is the national professional society of pharmacists in the United States, and its membership consists of more than 40,000 practicing pharmacists, pharmaceutical scientists and educators. Additionally, over 12,000 students enrolled in colleges of pharmacy hold student membership in APhA.

APhA member pharmacists practice their profession in a variety of settings. Some are owners of community pharmacies. Others are employed pharmacists in community pharmacies and in both nonprofit and for-profit hospitals. APhA itself has no commercial interest in any pharmacy, nor does it represent the proprietary interests of pharmacist owners of community pharmacies as such.

The APhA and, of course, its members are vitally interested in the public health and welfare as they may be affected by the profession of pharmacy. In that regard, APhA exists for the purposes of rendering assistance in improving, promoting, and safeguarding the public health and welfare by: (1) maintaining an official compendium of drug standards and specifications; (2) promoting the safe use of drugs; (3) fostering and encouraging inter-professional relations; (4) improving the art and science of pharmacy for the general welfare by the dissemination of scientific information relating to drugs; (5) providing a system of education and training in the art of pharmacy; (6) supporting a system of licensure and registration of pharmacists; (7) developing, maintaining and enforcing a code of ethics for pharmacists calculated to safeguard the public; and (8) cooperating with the United States Government to the fullest in conducting research, examinations, investigations, experiments and in disseminating information.

The National Association of Retail Druggists (NARD), is a nonprofit Illinois Corporation, established nearly a century ago, representing the pharmacists/owners of about 35,000 independent retail pharmacies in which approximately 75,000 of the 120,000 pharmacists in this country practice their profession and dispense about sixty to seventy per cent of the nation's out-of-hospital prescription needs. In addition to filling individual prescriptions, many NARD members provide pharmacy service, including drug needs and convalescent aids for nursing homes and small hospitals. Many APhA pharmacists, who are also community pharmacy owners, are also members of NARD.

The independent community pharmacist today is simultaneously a practitioner and a small businessman. NARD and its members, as does APhA and its members, vigorously support the American free enterprise system which provides the only meaningful climate under which a small business man can economically survive, have the opportunity to succeed by his own efforts, and perform an important and essential service to his community.

Both APhA and NARD and the members of each association have a vital interest in assuring the continued widespread availability of pharmaceutical service to the public when and where such service is required. For many persons, the pharmacist is the most readily-accessible health care professional and, in

addition to the generally-recognized drug dispensing services, the pharmacist serves as an initial point of contact or entry for those persons not having a regularized relationship with the health care system or its professional practitioners.

Both APhA and NARD recognize that the realities of pharmacy practice, as that practice has developed uniquely in this country, include various means and agencies through which pharmaceutical service is provided to the public under different social, economic and health care requirements. The only issue in the instant case, however, involves the providing of pharmaceutical service by nonprofit hospitals to ambulatory patients, hospital employees, staff physicians, and their respective families.

Today, pharmaceutical service is provided to noncharity ambulatory patients by both community pharmacies and hospitals. The latter have provided such service primarily only as a post-World War II activity and when so doing are in direct competition with community pharmacies. Your *amici* are dedicated to the preservation of adequate pharmaceutical service to meet public health needs. Both APhA and NARD recognize, however, that this objective will fail if one segment of competing pharmaceutical service providers is economically disadvantaged so that it is eliminated or threatened with elimination.

ARGUMENT

In essence, the Court of Appeals decision distinguishes between those patients who at the time of their treatment are unable to obtain needed prescription drugs other than in and from the hospital (i.e., bed-

ridden "hospitalized" patients and emergency room patients) and those patients or other individuals who are able to obtain needed prescription drugs outside of the hospital (i.e., "ambulatory" patients, hospital employees, staff physicians, and their respective families). It is clear that the Court of Appeals did not seek a "cubbyhole" approach, as characterized by the *amicus* American Hospital Association; rather, it dealt with specific categories of patients and dispensing/sales situations which were presented to it as a result of the course of the litigation in the district court below. The approach taken by the Court of Appeals is both sensible and sound from a legal and a public policy standpoint. While giving full force and effect to the clear language and purpose of the Nonprofit Institutions Act of 1938, 15 U.S.C. § 13c, the court's decision grants equal dignity (as it must) to the Robinson-Patman Act, 15 U.S.C. § 13.

A. The Court of Appeals decision properly applied the Section 13c exemption to nonprofit hospital pharmaceutical functions.

Both the petitioners and *amicus,* American Hospital Association (AHA), insist that the Court of Appeals misconceived the true nature and functions of nonprofit hospitals and, thereby, applied an erroneous test in determining what drugs were for a hospital's "own use". They further contend that the court's resolution of the issue imposes improper burdens and restrictions on hospital functions. The petitioners and AHA would have this Court adopt a rule under which only the hospitals themselves could determine what supplies were "for their own use," such a determination being based solely on the hospitals' self-concept of their nature and function. Whatever may be the nature

and function of nonprofit hospitals, the determination as to what purchases of supplies by such hospitals are "for their own use" must be based on a standard which is less mutable and more capable of practical application. Moreover, it should be clear that the judicial system should not be ousted of its jurisdiction in matters involving statutory interpretation.

The petitioners state: "The Court of Appeals applied a concept of the nature and functions of hospitals that is inconsistent with the facts of hospital operations and is contrary to the public interest." (Pet. Br. 16) Petitioners argue that the Nonprofit Institutions Act of 1938 was enacted to permit nonprofit hospitals to operate as inexpensively as possible, and, therefore, that any purchases of supplies which are to be used, in the hospital's judgment, as part of the "proper business of a modern hospital" fall within the exemption of that Act. This approach would excise from the Act the key phrase upon which the instant controversy centers.

The Act does permit hospitals to purchase supplies as inexpensively as possible, but only when the hospitals purchase such supplies for "their own use". As the Court of Appeals expressly held:

> "We may concede that in these respects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' 'own use.'" *Portland Retail Druggists Association, Inc.* v. *Abbott Laboratories, et al.*, 510 F.2d 486, 489 (9th Cir. 1974).

Petitioners place great reliance on the decision in *Logan Lanes, Inc.* v. *Brunswick Corporation*, 378 F.2d

212 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967) as supporting the theory that any purchases made pursuant to a "proper function" are purchases "for their own use." In that case, however, no *supplies* were being *resold* in competition with other sellers of similar supplies.

If a hospital maintains a staff conference room furnished and decorated with materials purchased under the Section 13c exemption, there could be no dispute that the materials had been purchased for the hospital's "own use." If the hospital also occasionally rents the room to unrelated groups and organizations for the holding of conferences and meetings by those groups, such activities and use would not deprive the initial sale of the furnishings and decorations of the coverage of Section 13c under the *Logan Lanes* standard. The maintenance of a staff conference room by a hospital is clearly a proper hospital function, and purchases of the furnishings and decorations would be for the hospital's "own use".

It is also a proper hospital function to purchase sick room supplies (*e.g.*, hospital beds, wheelchairs, bandages, etc.) and to furnish these supplies to bedridden "hospitalized" patients and to emergency room patients. This would clearly constitute the hospital's "own use" of the supplies under the Section 13c exemption. When the hospital decides, however, that the concept of its nature and "proper function" includes selling such supplies to departing patients, hospital employees and staff physicians for *their* use and the use of their families, would such "retailing" of sick room supplies constitute the hospital's "own use"? Surely not.

Extending the petitioners' approach even further leads to the conclusion that nonprofit hospitals may sell all manner of medical supplies and equipment to any member of the public the hospital sees fit to nominate a "patient". Such resales should be justified as the nonprofit hospital's "own use", petitioners and AHA urge, due to the ever-broadening self-concept of a hospital's "proper function" in the "ongoing expansion of outpatient and ambulatory services." In the instant case the Court of Appeals properly limited the hospitals' "own use" as required by Section 13c and made it clear that it is a matter for the courts, and not for the hospitals, to determine the parameters of "own use".

B. Hospitals have not been forced to perform the drug dispensing functions in issue.

Petitioners and the AHA note in their briefs the broad expansion of hospital ambulatory care services which has occurred since the end of World War II. They suggest that nonprofit hospitals have been forced to expand such services including drug dispensing to outpatients. In fact, this expansion of services by hospitals has been both voluntary and aggressive. At the outset, post-war expansion of hospital services, particularly those relating to outpatients, may have been thrust upon the hospitals by health care service shortages elsewhere. There exists substantial evidence, however, that hospitals have elected to turn unwanted adversity into a much sought-after advantage.

Rather than focusing on means to alleviate demand on hospitals for outpatient services, hospitals have chosen to increase the availability of such services to meet the demand. Moreover, there is clear evidence

that, in many instances, hospitals have sought to create a market for outpatient services rather than assist in resolving arguable shortages in ambulatory care services from other sources.

In March, 1968, the AHA convened a conference on "Outpatient Health Care." The report and recommendations of this conference published in 1969[1] reveal hospital objectives relating to out-patient services and outline the means by which those objectives are to be attained.

The preamble of the report and recommendations opens with the following statement of "fact" which sets the tone for all that follows:

> "Hospitals individually and collectively have evolved as the principle community locus where substantial health resources are congregated, either physically or organizationally. The general hospital stands today as the logical organization through which to develop a system for the provision of comprehensive health care for the total community." (p. 3)

That basic axiom is amplified in the same preamble by these observations:

> "Hospitals were organized originally to provide inpatient care. Today, in the light of changes that have taken place in medical practice in the delivery of health care, it is imperative that equal consideration be given to outpatient services."
>
> *"Conferees agreed that the hospital of the future should become an ambulatory care center with inpatient beds attached, rather than a concentration*

---

[1] AMERICAN HOSPITAL ASSOCIATION, OUTPATIENT HEALTH CARE (1969).

> ***of beds with outpatient facilities attached.*** The core of the hospital may remain intensive inpatient care, but its major service to the community should be ambulatory care. . . . ***Such a role may involve the hospital in operating satellite units of various types.***" [Emphasis added]

In a list of several "premises" seen by AHA as justification for the expansion of hospital outpatient services, there is found an interesting observation concerning the future availability of health care services for ambulatory patients:

> "As in the past, the majority of patients will receive much of their outpatient care in the offices of their private physicians. However, an increasing proportion of patients will require the use of expensive diagnostic and treatment facilities, usually centralized in hospitals. This will reinforce the desirability of locating physicians offices in or adjacent to the hospital, or in a physical grouping capable of supporting satisfactory diagnostic and treatment services, utilizing the full potential of modern automated techniques." (p. 7)

Thus, recognizing that hospitals would not likely supplant the private office practice of individual physicians, a rationale is presented for drawing such physicians (and their patients) more directly within the influence and control of the hospital. Paradoxically, the AHA desire that hospitals create centralized hospital-physician complexes can only be expected to exacerbate another problem "premise" noted as follows by AHA:

> "For the foreseeable future, there will be limited resources available to provide health care. And, as is often true in a free society, the problems of

> scarce health resources are likely to be compounded by maldistribution." (p. 8)

The essence of the AHA rationale justifying the expansion of hospital ambulatory care facilities and services neatly serves the interests of those hospitals AHA represents and may be summarized as follows: 1) A major inadequacy of the existing health care system is maldistribution of health care facilities and personnel; 2) The existing health care system is inadequate to meet public requirements for ambulatory care and there is a lack of reasonably accessible health care services for patients; 3) Hospitals must "take up the slack" in the existing health care system by increasing ambulatory care services in a centralized facility and/or by creating "satellite" ambulatory care centers.

Under such a strategy, of course, "the general hospital . . . as the logical organization through which to develop a system for the provision of comprehensive health care for the total community" becomes a self-fulfilling prophecy. AHA would create a health care system in which patients will be drawn to centralized hospital facilities either by expansion of ambulatory care services at such facilities or by drawing physicians into closer physical contact with such facilities. Those patients who may not be drawn to centralized facilities can be captured through the simple device of establishing "satellite" facilities which are readily accessible to patients. In the case of ambulatory care pharmaceutical services, at least, community pharmacies are unable to compete with the nonprofit hospital because of the significant economic advantages available to the hospital drug purchases made under the Section 13c exemption.

It might be expected that the expansion services urged for hospitals in 1969 would be an impossible burden on hospital capital and operating budgets, in light of the representations on behalf of hospitals found in the legislative history of the 1938 Nonprofit Institution Act. However, the answer to this dilemma is also found in the AHA report and recommendations on outpatient health care:

> "In the foreseeable future, health insurance programs will be expanded and new methods of providing and broadening coverage for outpatient care will be devised. As a result, almost all patients—be they outpatients, inpatients, or homepatients—will have their care paid for by some third party, public or private, or will pay directly for medical care services. *The 'charity patient' is disappearing.*" (p. 7) [Emphasis added.]

The fact that certain charitable burdens of "nonprofit" hospitals are being eliminated bears directly and substantially on the issue before this Court. While petitioners and the AHA place great emphasis and reliance upon the obvious congressional purpose underlying the Section 13c exemption, that of assisting "charitable" hospitals to serve the "needy sick," it is now readily apparent, as noted by the AHA itself, that within a relatively short period of time, if not already, the "needy sick" will have evaporated as an economic factor in hospital operation. The fact is, that since enactment in 1965 of the Medicare and Medicaid programs, the "needy sick" rationale for the Section 13c exemption has been virtually eliminated.

C. Hospital dispensing of drugs purchased under the Section 13c exemption to ambulatory care patients has had a significant adverse economic impact on community pharmacies.

Available data demonstrate that, since the end of World War II, hospitals have made incredible inroads in the "ambulatory care market." They have done so, in the case of pharmaceutical service, at the expense of community pharmacies.

The argument of your *amici* should not be construed as suggesting that the efforts of hospitals to increase the scope and volume of their ambulatory care services are improper. Such services, in the words of the Court of Appeals, may well be deemed "proper hospital functions". The issue in this case is not whether hospitals are to be permitted to compete with community pharmacies in dispensing drugs, but whether they are to be permitted to compete with an economic advantage which threatens to destroy competition rather than preserve it. As illustrated in Table I of the appendix, evidence exists that this economic advantage held by hospitals has already had a significant adverse impact on community pharmacy practice.

As initially stated, the interest of your *amici* is that of maintaining adequate, readily accessible pharmaceutical service for patients through the preservation of community pharmacies and community pharmacy practitioners as a competitive force in the marketplace. The rationale of the Robinson-Patman Act demands the preservation of this competitive force and prohibits the concentration of the ambulatory care pharmaceutical service in hospitals by means of an unfair advantage.

In its brief, respondent, Portland Retail Druggists Association, sets forth extensive data demonstrating the

destructive effects on competition by nonprofit hospital ambulatory care pharmaceutical service fostered by discriminatory prices granted hospitals in the Portland, Oregon area by petitioners. Your *amici* would supplement this localized information with data providing a broader national view.

In 1962, a total of 3,346 nongovernmental, nonprofit hospitals reported a total of 45.9 million hospital outpatient visits. In 1974, 3,577 such hospitals reported a total of 132.9 million hospital outpatient visits—an increase in just over 10 years of 189.5%.[2]

Total revenues attributable to outpatient services in 1974 for nongovernmental, nonprofit hospitals amounted to $2,823,387,000, or an approximate $789,000.00 per hospital.

While these figures convey the enormity of the increase in hospital outpatient visits during the past 10 to 15 years, they do not illustrate the effect of such increases in the pharmaceutical service area specifically. To assist this Court in its evaluation of this impact, your *amici* urge analysis of the data summarized below and presented in tabular form in Table I of the appendix.

In 1948, the National Association of Boards of Pharmacy (NABP), whose membership includes all state pharmacy licensing agencies, reported the existence of 46,932 community pharmacies, but only 1,221 pharmacies located in hospitals. By 1973, these figures had risen to 50,602 and 5,174 respectively. These figures indicated that while the number of hospital pharmacies had increased over this 25-year period by

[2] American Hospital Association, 1974 Hospital statistics, Tables 1 and 3.

323.8%, community pharmacies had only increased 7.8%. And, this 7.8% increase is misleading.

By 1962, according to NABP, community pharmacies had increased from 1948 levels to 48,841, while hospital pharmacies had increased in that period to 2,911. Hospital pharmacies had, therefore, increased between 1948 and 1962 at a rate of more than five times that of the rate of increase of community pharmacies. However, of greatest significance is the fact that in the period 1962-1973, community pharmacies decreased by 8,239 (−14.0%) while hospital pharmacies increased by 2,263 (177.7%).[3]

While community pharmacy and hospital pharmacy population data are indicators of the competitive impact of hospital outpatient pharmaceutical services, the most direct comparison can be made on the basis of data comparing prescriptions dispensed by community pharmacies versus prescriptions dispensed by hospital outpatient services.

In 1962, hospitals dispensed a total of 53.2 million outpatient prescriptions while community pharmacies dispensed a total of 702.0 million prescriptions.[4] By 1962, therefore, hospitals had acquired 7% of the ambulatory patient pharmaceutical service market. By 1970, the latest year for which such data are available, community pharmacy dispensing had increased to 1.07 billion prescriptions while hospital outpatient dispensing had increased to 149.0 million prescriptions. Thus, in less than 10 years, hospitals had acquired 12.2% of the entire ambulatory care pharmaceutical service market, an increase of 180.1% over 1962, while community

[3] NABP data is for all hospitals. *See* Table 1 of the appendix.

[4] *American Druggist*, June 6, 1966 and August 8, 1971. Hospital data are for all hospitals.

pharmacies prescription volume had increased at a rate of only 52.4%.

While the total number of ambulatory care prescriptions had increased during the period 1962-1970, in large part due to enactment in 1965 of the Medicare and Medicaid programs and the increase in pharmaceutical service "fringe" benefits for many employee groups, the clear trend evidenced by this data shows that hospitals have made substantial gains in their objective of expanding outpatient pharmaceutical service as one component of total hospital ambulatory care services.

Your *amici* suggest that dramatic increases in hospital outpatient dispensing and concomitant decreases in the number of existing community pharmacies are largely attributable to the preferential pricing practices which petitioners and AHA seek to defend as legitimate under the Section 13c exemption. Such a "cause and effect" relationship is suggested by data relating to pharmaceutical services in small (less than 100 beds) hospitals in the period 1962 to 1974.[5]

In 1962, only 4.4% of 6-24 bed nongovernmental, nonprofit hospitals reported operated a pharmacy. For hospitals with 25-49 beds the figure was 19.0%, and less than half (43.6%) of those hospitals having 50-99 beds operated a pharmacy in that year. Thus, only 22.3% of all hospitals having fewer than 100 beds had their own pharmacies as late as 1962.

By 1974, there had occurred a striking change in the small hospital pharmacy service picture. Thus, almost three-fourths (73.4%) of such hospitals reported were operating their own pharmacies in 1974. For those

[5] *See* Table II of the appendix.

hospitals having from 6-24 beds, the figure had risen from 4.4% in 1962 to 57.7% in 1974. Hospitals having 25-49 beds increased their percentages to 72.2% from 19%, and hospitals with 50-99 beds more than doubled their percentages figure from 43.6% to 90.4% during this period. As indicated previously, during this same general time period the number of community pharmacies declined by 14.0% .

While no data is known to exist illustrating the exact nature of the communities in which 8,239 community pharmacies failed during the period 1962 to 1973, it can be observed that "small" hospitals are generally found in "smaller" communities. In communities having hospitals of less than 100 beds, the number of community pharmacies is extremely limited, frequently one or two and seldom in excess of five or six. Although the typical small-town community pharmacy also must engage in the sale of general merchandise to remain economically viable, the professional practice of pharmacy is the base upon which its continued existence depends.

"Smaller" communities are frequently rural and serve populations which are proximate to both the community pharmacy and the hospital or populations which must travel to the community from outlying areas. In either case, pharmaceutical service from both a community pharmacy and the hospital is readily accessible and location becomes relatively unimportant for such patients. In such communities, it would be expected that hospital outpatient dispensing based on preferential prices would have a more severe impact on community pharmacy services than would occur in metropolitan areas. In the latter situation, the adverse impact would be expected to fall primarily on community pharmacies in close proximity to hospitals dispensing to ambulatory care patients.

In smaller communities particularly, the ability of hospitals to control the pharmaceutical service market for ambulatory care patients is more than just a possibility. Your *amici* have been the recipients of numerous complaints from their members in smaller communities regarding the "unfair" competition of hospitals dispensing to ambulatory care patients with the economic advantage derived from the preferential pricing practices of petitioners and other pharmaceutical manufacturers relying on the Section 13c exemption.

D. This Court must reject the "primary purpose" test advanced by AHA.

The *amicus* AHA urges this court to reject the Court of Appeals' approach to the specific limited issues before it in the instant case and to promulgate rather a broad "primary purpose" test to determine the applicability of the Section 13c exemption. Under the primary purpose test constructed by AHA, the nonprofit hospital would be the sole determiner of the breadth of the exemption and would effectively oust the courts of jurisdiction to exercise their own judgments. Thus, the AHA argues (AHA brief pages 24, 25) that the hospital should be permitted complete freedom to determine what are proper functions for it to perform and that purchases made in connection with whatever functions selected should be equated with purchases for the hospitals "own use" within the meaning of the Section 13c exemption.

Thus, if one accepts this argument, one concedes to nonprofit hospitals the right to decide that proper hospital functions include the operation of hospital "satellite" pharmacies next door to and in direct competition with community pharmacies with the drugs

dispensed by the satellite hospital pharmacy subject to the Section 13c exempion. Such a situation would have to be accepted by the courts, because according to the AHA argument, the hospital had concluded by and for itself that such drug distribution was "a proper hospital function." Your *amici* respectfully suggest that this result of the primary purpose test urged by AHA as thus applied is a patent absurdity and clearly outside the beneficent purpose of Congress when it enacted the Nonprofit Institution Act.

CONCLUSION

Your *amici,* the American Pharmaceutical Association and the National Association of Retail Druggists, fully endorse and support the arguments advanced by respondent urging affirmance. The decision of the court below is sound and fundamentally correct in limiting a nonprofit hospital's dispensing of drugs purchased at a discount to conform to the clear intent of Section 13c while at the same time giving proper effect to the purposes of the Robinson-Patman Act and helping to assure the continued viability of the community pharmacy as a valuable community asset. Your *amici* also respectfully urge affirmance of the court below.

Respectfully submitted,

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APPENDIX

APPENDIX

Table 1

Comparative Growth Data: Hospital Pharmacies v. Community Pharmacies

	Community Pharmacies	Hospital Pharmacies	% NGNP Hospitals w/Pharmacies
Number as of 1/1/48	46,932	1,221	
Number as of 1/1/62	58,841	2,911	60%
% Change '48-'62	+25.4%	+138.4%	
Number as of 1/1/73	50,602	5,174	89.8%
% Change '48-'73	+7.8%	+323.8%	
% Change '62-'73	—14%	+177.7%	
Prescriptions'* '62	702,016,000	NG 21,742,000 All 53,200,000	
Prescriptions * '70	1,070,194,000	NG No data All 148,999,000	
% Change '62-'70	+52.5%	NG — All +180.1%	

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* "Prescriptions" for hospitals=sales to *out*patients.

NG=Non-government.

NGNP=Non-government nonprofit.

The above data were collected from the following sources: NATIONAL ASSOCIATION OF PHARMACY PROCEEDINGS 1963; NATIONAL ASSOCIATION OF BOARDS OF PHARMACY, PROCEEDINGS 1974; AMERICAN DRUGGIST (June 6, 1966); AMERICAN DRUGGIST (Aug. 9, 1971).

Table II

Growth Data: Percentage of Hospitals Having Pharmacies

Type of Hospital	Total Number	Total No. W/Pharmacy	% With Pharmacy
1962—All NGNP	3,290	1,975	60.0%
1974—All NGNP	3,434	3,124	91.0
By No. of Beds			
'62 NGNP (6-24 beds)	203	9	4.4
'74 NGNP	104	60	57.7
'62 NGNP (25-49 beds)	643	122	19.0
'74 NGNP	424	306	72.2
'62 NGNP (50-99 beds)	835	364	43.6
'74 NGNP	674	609	90.4
'62 NGNP (100-199 beds)	764	648	84.8
'74 NGNP	826	810	98.1
'62 NGNP (200-299 beds)	445	432	97.1
'74 NGNP	515	514	99.8
'62 NGNP (300-399 beds)	227	227	100.0
'74 NGNP	312	311	99.7
'62 NGNP (400-499 beds)	92	92	100.0
'74 NGNP	185	185	100.0
'62 NGNP (500+ beds)	81	81	100.0
'74 NGNP	212	211	99.5

NGNP=Non-government nonprofit.

The above data were collected from the following sources: AMERICAN HOSPITAL ASSOCIATION, 1974 HOSPITAL STATISTICS, Table 3 and Table 12A.

Supreme Court, U. S.
FILED
DEC 1 1975
MICHAEL RODAK, JR., CLERK

No. 74-1274

In the Supreme Court

of the United States

OCTOBER TERM, 1975

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

PETITIONERS' REPLY BRIEF

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ABBOTT LABORATORIES, an Illinois corporation, et al.,

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PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITIONERS' REPLY BRIEF

INTRODUCTION

In view of the narrow question before the Court, respondent's broadside attack upon the pharmaceutical industry (Resp. Br. 5-7, 12-16) is unjustified and irrelevant. The hospitals, not petitioners, decide how their drug inventories shall be used, and the only question to be decided is whether the hospitals' purchases of drugs are for their "own use". The price

differences which concern respondent reflect policies that have been in effect for many decades and were given legislative sanction in the Nonprofit Institutions Act. The proper forum for respondent's free-ranging discussion is the Congress, not this Court.

Two other preliminary comments on respondent's brief are appropriate. Respondent's statistical representations (Resp. Br. 19, 24-25) are derived principally from evidence relating to drug dispensing by Bess Kaiser Hospital, which, we have noted elsewhere (Pet. Br. 6, fn. 3), is affiliated with a health maintenance organization that primarily serves its own members.[1] The Court of Appeals concluded that the application of Section 13c to Bess Kaiser's drug purchases could not be determined from the record, and it ordered further discovery without adjudicating that issue (App. 308-309). None of the parties sought review of that aspect of the Court of Appeals' decision. Consequently, the application of Section 13c to drug purchases of this HMO-affiliated hospital is not before the Court, and respondent's use of the Kaiser statistics is improper.[2]

A second and more serious aspect of respondent's brief is its reliance on material that is not in the record and its erroneous statements about material that

[1] Ninety-nine percent of Kaiser's drug distribution is to its own members; its "indiscriminate" sales to the public (Resp. Br. 30) amount to one walk-in prescription per day at each pharmacy (Pirtle Dep. Ex. 2).

[2] Nor are respondent's references to the depositions of Pirtle (fns. 10, 13, 37, 39, 58) and Greenlick (fn. 41) relevant to the issue before the Court. These witnesses are Kaiser officials who testified about Kaiser operations in Portland.

is in the record. Petitioners take particular exception to respondent's extensive misuse of 1967 testimony before a congressional subcommittee, as if it were evidence in the record of this case. Some of these matters are referred to in the discussion that follows, and others are noted in the exhibit to this brief, at p. 15 below.

I.

Respondent Had Full Discovery With Respect to the Section 13c Exemption, and the Record Was Sufficient to Decide Petitioners' Motion for Partial Summary Judgment.

From the time it was first filed as a class action, this was a complex case involving a multitude of Robinson-Patman Act and other antitrust claims,[3] and the district court properly proceeded with a "method and schedule" for resolving preliminary legal questions. *Manual for Complex Litigation*, Par. 1.80. The court first considered and finally dismissed charges of discrimination in government sales. Discovery then proceeded on the Section 13c exemption question as a segregated issue (see Pet. Br. 4; Tr. 9/11/72 at pp. 29-30, 117-124). Respondent conducted broad and extensive discovery of the nonprofit hospitals' drug dispensing practices (see Tr. 11/27/72 at pp. 3-15). It deposed (and in some instances redeposed) more than 40 hospital pharmacists and administrators and other witnesses; it subpoenaed all of the hospitals' records

[3] By taking assignments from some 60 assignors of their respective claims against 11 defendants, plaintiff sought to litigate literally hundreds of Robinson-Patman and Sherman Act claims in this single action.

relating to drug distribution; and it filed 17 documents, entitled "Rule 56 Affidavits", totalling more than 300 pages, and 13 other affidavits, statements and exhibits. As a result, both the district court and the Court of Appeals accepted the record as sufficient to determine the application of the exemption to drug purchases by the 13 nonprofit hospitals in Portland.

The fact is that respondent had substantially all of the discovery it sought — and certainly all it needed—on the issue of the Section 13c exemption. Indeed, respondent has admitted this. In its brief in this Court opposing American Hospital Association's motion for leave to file an *amicus* brief supporting the petition for certiorari, respondent asserted that AHA's presentation could not help the Court, because AHA assumed the record was incomplete "when, in fact, the record was extensive, i.e., some 50 depositions and thousands of pages of exhibits, and *more than adequate for the issues decided*" (Resp. Obj. 2; emphasis added).

The district court did not abuse its discretion in considering and ruling on petitioners' motion for summary judgment. *First Nat. Bank* v. *Cities Service Co.*, (1968) 391 U.S. 253, 299.

II.

Respondent's Brief Misconceives the Issues and the Positions of the Parties.

Respondent's brief displays basic misconceptions about the issues raised by the record and the positions of the parties toward them. As a result, those matters must be clarified.

1. Petitioners have not "shifted their position", nor have they "accepted" the Court of Appeals' decision excluding various categories of drug use by the Portland area hospitals.

Respondent's contention that petitioners have "accepted" the Court of Appeals' decision as to marginal categories of drug dispensing is incorrect (Resp. Br. 3-4, 59, 66).

The question to be decided is whether the Court of Appeals erred in limiting the Section 13c exemption to inpatient and emergency room use and excluding other drug uses, principally take-home drugs and drugs dispensed to outpatients and to staff and employees for personal and family use (App. 311-312). The first two of these are a direct service to registered hospital patients, and the third strengthens and assists the hospital's internal administration (Pet. Br. 3, 10-12; Tables 2-4 at Pet. Br. 32-34).

As noted in petitioners' opening brief, other uses of drugs by nonprofit hospitals referred to by the Court of Appeals occur infrequently, if at all, and not in significant amounts (Pet. Br. 7, 12; Tables 5-6 at Pet. Br. 35-36). However, petitioners have not "accepted" the Court of Appeals' decision as to such uses. Occasional sales of drugs to nonpatient members of the public ("walk-in" customers), usually at night or on weekends or in other emergencies, or in similar circumstances to doctors and other hospitals, have no commercial significance and are a necessary accommodation to the community's medical needs. These uses,

while peripheral, constitute hospital use of drugs within the meaning of Section 13c.

2. Nonprofit hospitals are not operating retail drugstores, and there is no issue as to the application of Section 13c to a hospital pharmacy operation that "cannot be distinguished" from a commercial drugstore.

Respondent states that its dominant concern is with the hospital that acquires drugs at reduced prices and ". . . *chooses not to use them for a hospital purpose, but decides to conduct an operation which cannot be distinguished — save for location — from that conducted by a drug store pharmacy.* . . . (Resp. Br. 35; emphasis in the original). This central proposition ignores the record facts. As we have stated before, these nonprofit hospitals do not operate general retail drugstores. In fact, the record shows that they discourage or even refuse to make sales that are not directly related to the functioning of the hospital (see Pet. Br. 8-12, 31-36). There is no evidence, despite the fears of APhA (APhA Br. 5-6), that nonprofit hospitals can or do engage in general retail operations with supplies purchased under the Section 13c exemption.

We recognize and agree that purchases of supplies under Section 13c should promote hospital operations and services. All of the uses now under consideration meet that standard and are within the scope of the exemption.

3. The contention that drug distribution by nonprofit hospitals has caused competitive injury to community pharmacies is not before the Court and is not supported by the record.

The question before the Court is limited to the proper interpretation of Section 13c. Respondent's claim that hospital drug distribution has caused competitive injury to retail pharmacies, which would be necessary to a *prima facie* showing of a violation of the Robinson-Patman Act, is not before the Court (see pp. 9-10 below) and was not considered by the district court or the Court of Appeals.

Furthermore, the record does not support the contention of respondent (Resp. Br. 18-25) and APhA (APhA Br. 13-18) that hospital drug distribution has injured retail pharmacies. There is no discernible basis in the record for the contention that "In Portland more than half the drug stores have closed within the past ten years" (Resp. Br. 23). Exhibits to the deposition of A. G. McLain, Secretary of the Oregon State Board of Pharmacy, summarizing the records of the Board for the period from 1965 to 1972, show that the total number of community pharmacies in the entire tri-county area declined by just 33 during that period, from 180 to 147 (McLain Dep. Ex. 2).[4]

Nor do the maps attached to respondent's brief support the assertion that "the locations most acutely affected are those closest to the hospitals" (Resp. Br.

[4] The Oregon State Board of Pharmacy defines a "community pharmacy" as "a licensed pharmacy independently owned and operated". It is one of seven different classes of pharmacies regulated by the Board (McLain Dep. Ex. 2).

24).[5] On the contrary, they show that 33 closures occurred in the downtown core area of Portland, where there are no nonprofit hospitals.

It is scarcely credible that a minor portion of the drug sales of Portland nonprofit hospitals is responsible for the decline in the number of community pharmacies in the tri-county area. It is more probable that the retail drug business, like other businesses, has merely shifted to larger stores in suburban areas. This is suggested by Appendix I (p. 1a) of APhA's *amicus* brief, which shows that from 1962 to 1973 there was a 14 percent net decline nationally in the number of "community pharmacies," but that in 1970 this declining number of pharmacies filled 52.5 percent *more* prescriptions than in 1962. Thus, while the number of community pharmacies was declining, their total volume of prescription drug sales was sharply increasing.[6]

While not essential to the Court's decision, there is no basis in the record for contending that there has

[5] The three unidentified maps attached to respondent's brief are something of a mystery: Maps similar to two of them were received as exhibits to an affidavit of Mr. Howard Steinbach, one of plaintiff's assignors (App. 153-154; R. 541-542, 866-867). The "spheres of influence" shown on one of those maps and also on the third one attached to the brief apparently represent Mr. Steinbach's — or somebody's — opinion of the geographic effect of hospital sales.

[6] Figures in the same APhA appendix showing that the number of hospital outpatient prescriptions also increased during the same period do not distinguish between prescriptions filled by nonprofit hospitals which qualify for the Section 13c exemption and prescriptions filled by proprietary hospitals which do not, or by government hospitals whose purchases are not subject to the Robinson-Patman Act.

been a decline of the corner drugstore as the result of drug distribution by nonprofit hospitals having the benefit of Section 13c.

III.

All Hospital Drugs that Are Dispensed in the Course of Providing the Institution's Health Care Services to the Community Are Within the Section 13c Exemption; the Narrow Locational Test of Hospital Use Proposed by Respondent is an Incorrect Construction of the Nonprofit Institutions Act.

1. The Section 13c exemption applies to all supplies used by a nonprofit hospital, even if such use may involve competition with retail drugstores.

The Section 13c exemption from the Robinson-Patman Act is absolute, and it applies to all uses of drugs by nonprofit hospitals, whether or not they might be regarded as competitive with the business of commercial drugstores. In passing the Nonprofit Institutions Act of 1938, Congress favored certain activities over others. The exemption was a considered determination of social and economic policy that nonprofit hospitals and similar institutions should be permitted to purchase their supplies at favorable prices, whether or not such purchases might result in detriment to others. The possibility that this may cause a loss of sales to other economic entities is not only contemplated by Section 13c, but is inherent in its exemption, since the Section 13(a) prohibition against discriminatory sales applies only where there is a possibility of competition.

Section 13c exempts from the Robinson-Patman Act

purchases by nonprofit hospitals of supplies for their "own use", which includes all supplies used in carrying on the institutions' functions. The Court of Appeals correctly held that all of the disputed drug dispensing activities of these hospitals are proper hospital functions. It follows that hospital purchases of drugs for those purposes are within the scope of Section 13c, whether or not retail druggists could supply some part of them.

This analysis of Section 13c, as applied to the use of drugs by nonprofit hospitals, is responsive to the considered findings of Congress in the National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 300k, 88 Stat. 2226, that

> ". . . (4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and immediate care for inpatient hospital care.
>
> "(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels."

2. The Section 13c exemption is not limited to supplies that are purchased for use within the walls of the institution.

a. Respondent and amici curiae supporting the

decision of the Court of Appeals contend that Section 13c applies only to purchases of drugs for use in ways that cannot be supplied by retail drugstores (described as uses that are not on "the same functional level", Resp. Br. 33; APhA Br. 4-5, 13; So. Assn. Br. 11-13). Respondent expresses this as a locational test, contending that the exemption applies only to drugs purchased for consumption on hospital premises (Resp. Br. 19, 33-34, 40-46, 63, 65).[7]

Section 13c contains no such restrictions. It is not limited to supplies purchased for use at particular "functional levels" or within the walls of the institution, but extends generally to all purchases for the institution's use. The question is whether the "use" of supplies by a hospital, a church or a school is coextensive with admittedly appropriate functions of the institution. In the case of a hospital, its services to the sick, including pharmaceutical services, are supplied through integrated operations to ambulatory[8] as well as to bedridden patients. It is unrealistic to di-

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[7] In adopting this test, respondent concedes, contrary to the decision of the Court of Appeals (App. 311-312), that some outpatient distribution is the hospital's "own use". Establishing categories of "own use" for churches or schools, which also provide supplies to their members in the course of their activities, would be at least as difficult as doing so for hospitals.

[8] Respondent's assertions that ambulatory patients are not hospital patients, or are not "hospitalized" (Resp. Br. 19, 33, 49, 52, 63), are incorrect; outpatients are registered patients of the hospital, and take-home drugs are dispensed to registered patients before they leave the hospital. APhA refers to both outpatients and departing inpatients as "ambulatory" (APhA Br. 4), whereas none of them are necessarily ambulatory — one knows only that they do not occupy hospital beds (cf Resp. Br. 37, 56).

vide such operations, as the Court of Appeals divided them, between some that are and others that are not the hospital's "own use".[9]

The disputed drug uses are concededly appropriate for nonprofit hospitals, but were excluded from the exemption by the Court of Appeals (App. 310-311) because some of them can be supplied, in whole or in part, through traditional retail channels. But it is precisely in these cases that the exemption has significant operation, and the Court of Appeals, like respondent, misconceived the issue in seeking to limit hospital drug "use" to activities that cannot overlap retail operations.

b. Drugs administered to bed patients are not sold in competition with retail pharmacies. It would be illogical to conclude that Congress passed Section 13c to protect discounts which have no competition impact and do not violate Section 13(a). The purpose of Section 13c was not to "clarify" the Robinson-Patman Act (Resp. Br. 34), but to exempt from the Act discounts granted to institutions operating in the public interest,

[9] Like the Court of Appeals, respondent would construe the statute to equate "use" and "consumption" and distinguish drugs that are "used" from those that are "sold" (Resp. Br. 11, 27, 40-46). However, drugs supplied to inpatients as well as to outpatients are billed to them and are paid for as part of their hospital charges. The hospital does not "consume" any of the drugs that it purchases (see Pet. Br. 21-22), but this does not affect the application of Section 13c. In *Logan Lanes, Inc.* v. *Brunswick Corporation*, (9th Cir. 1967) 378 F.2d 212, cert. den. (1967) 389 U.S. 898 the court held that the exemption applies to all purchases of supplies for the institution's use, whether they are "consumed *or otherwise disposed of*" (378 F.2d at 216; emphasis added).

discounts that could otherwise be illegal. The legislative history shows that the beneficiaries of Section 13c were not granted the exemption because their operations would never impinge on the business of others, but because they perform important public services without the prospect of private gain. An exemption adopted on that basis cannot be limited to uses that by definition do not affect retail markets.

c. "Generalized statements"[10] that antitrust exemptions must be narrowly construed have no application to Section 13c. This is not a case in which an exemption is sought to be implied from a scheme of statutory regulation, e.g., *U.S. v. National Ass'n. Securities Dealers*, (1975) — U.S. —, 95 S. Ct. 2427, 2443, 45 L. Ed. 2d 486, or in which a challenged practice contravenes a limitation in an express statutory exemption that is "as plain as words can make it", *United States v. McKesson & Robbins*, (1956) 351 U.S. 305, 313.

Section 13c expresses a particular social policy that was deemed to be more important than the policy of the Robinson-Patman Act. A narrow construction of a statute that expresses such a social policy is inappropriate. *Logan Lanes, Inc. v. Brunswick Corporation*, supra, (9th Cir. 1967)) 378 F.2d 212, 216, *cert. den.* (1967) 389 U.S. 898. Section 13c, being a corrective statute, should not be narrowly construed. *Galvan* v. *Press*, (1954) 347 U.S. 522, 527; *Rowoldt* v. *Perfetto*, (1957) 355 U.S. 115, 120.

[10] See Report of Committee on Antitrust Exemptions, 33 ABA Antitrust Law Journal 1, 5 (1966).

CONCLUSION

The hospital drug uses that are in controversy are within the Section 13c exemption. The judgment of the Court of Appeals should be reversed, and the district court's summary judgment construing Section 13c should be reinstated.

Respectfully submitted,

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GARRY P. MCMURRY
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ALLAN HART
Counsel for Petitioner A. H. Robins Company, Incorporated
BARNES H. ELLIS
Counsel for Petitioner William H. Rorer, Inc.

December 1, 1975.

EXHIBIT TO PETITIONERS' REPLY BRIEF

The Court's attention is called to the following inaccuracies and improprieties in respondent's brief:

1. Respondent refers to testimony given before a congressional subcommittee in 1967 as if it were evidence in this record and probative of issues in this case (see footnotes 19, 20, 21, 24, 25, 26, 27, 28, 29, 38, 51, 52, 53, 57, 58, 62, 72, 96).

2. Respondent refers to first cause of action depositions which were taken long after entry of the summary judgment on the second cause of action from which this appeal was taken (see footnotes 8, 9, 13, 19, 24, 25, 27, 28, 29, 34, 35, 37, 38, 39, 40, 51, 54, 109, 110).

3. In citing the testimony of Mr. Earl Kintner before a congressional subcommittee, respondent refers to him as a "former FTC Chairman", see Resp. Br. 59-60, whereas in fact Mr. Kintner testified as counsel for the National Association of Retail Druggists. Hearings, Small Business Problems in the Drug Indusdustry, Subcommittee on Activities of Regulatory Agencies, House of Representatives, 90th Cong., 1st Session at p. 9 (1967).

Respondent's quotation from Mr. Kintner's testimony (p. 59) is also misleading. The question to the witness was:

> "It would be highly unusual, however, for there to be a special purchasing program in behalf of the in-house pharmacy?"

Mr. Kintner's answer, in language not referred to by respondent, commences:

"It would be highly unusual, but * * * ".

Respondent does not suggest the existence, much less the substance of the omitted language.

4. In footnote 38 (p. 17) respondent cites the testimony of hospital witnesses about walk-in sales, but does not refer to testimony of the same witnesses that such sales are limited to cases of immediate need and are negligible in amount (Table 5 at Pet. Br. 35). Similarly, in footnote 40 (p. 18) respondent does not refer to testimony of the same hospital witnesses, that sales of drugs to other hospitals, clinics or drugstores are limited to cases of immediate need and occur rarely (Table 6 at Pet. Br. 36). None of the testimony cited by respondent supports the suggestion in its brief that these kinds of sales are ongoing commercial practices of any nonprofit hospital.

5. The following additional comments on footnotes in respondent's brief are also appropriate:

Footnote 7: The citation is to statements in one of respondent's briefs in the district court (R. 833, found at App. 277).

Footnote 16: The reference is to testimony given before a congressional subcommittee regarding cross-sales, not cross-licensing (R. 133).

Footnotes 26, 31: Respondent contends, based on statements in a House committee report about alleged quantity limitations on sales to retailers, that the

products themselves are not available to retailers. The references do not support the assertion, and there is no evidence in the present record that this happens.

Footnote 32: The reference does not support the statement in the text for which it is cited, i.e., that one of the petitioners gives "extra time for payment" to hospitals that is not given to retailers.

Footnote 39: The references to R. 938 and R. 941 do not support the statement in the text for which they are cited, i.e., that hospitals refill various kinds of prescriptions. The testimony of the hospital witnesses, including the testimony cited by respondent, establishes that with few exceptions the hospitals do not refill take-home prescriptions (see Table 2 at Pet. Br. 32).

Footnote 46: The reference does not support the statement in the text for which it is cited, i.e., that a prescription is written for a drug to be used by one who is "no longer a patient or who was never a patient".

Footnote 49: The references to R. 744, R. 746 and R. 897 do not support the statements in the text for which they are cited, consisting of recitals of the numbers of prescriptions assertedly written by unidentified hospitals over a period of two to four years.

Footnote 58: None of the 13 citations to deposition testimony support the statement in the text for which they are cited, i.e., that hospitals sell drugs at prices below those charged by retailers and lower than retail

drugstores must charge "to economically survive". Charges of such practices made before a congressional subcommittee in 1967 are not probative of facts in this case.

Footnote 62: The certificate referred to in the second paragraph of the footnote was filed in the district court on September 15, 1975, more than two years after entry of the district court's judgment and about a week before respondent filed its brief in this Court. It also shows that 23 new pharmacies opened between January 1, 1971 and May 23, 1975, including 12 in 1971 and 1972, and that the figures cited by respondent are for the entire tri-county area, not Portland alone.

Footnote 70: The references do not support the statement in the text for which they are cited, i.e., that patients at doctors' offices near hospitals purchase drugs at hospital pharmacies. To the extent that the references bear on any issue, they show only that sales to doctors are negligible.

Footnote 99: The references contradict the statement in the text that a Portland hospital refuses to accept indigents.

Footnote 100: The reference to R. 939 is to a list of attorneys contained in the clerk's docket.

Footnote 105: The current (1975) Portland telephone directory does not support the statement in the text for which it is cited, i.e., that drugstore service (including delivery service) is widely available in Portland 24 hours a day. It shows that nearly all

drugstores operate only during regular business hours or in the early evening, and most are closed on weekends or Sundays. Out of 211 listings for the Portland-Burlington-Lake Oswego-Milwaukie area, only six advertise after-hours emergency service.

Footnote 107: There is no evidence that any of these hospitals in the Portland area has a separate pharmacy for outpatients.

Footnote 109: The references do not support the statement in the text for which they are cited, i.e., that drug representatives visit hospitals "to keep close tabs on the drug needs of their hospital customers" and to check their drug stocks.

Appendix footnotes 24 and 25: The article referred to by respondent, published in 1941, does not support the statement in the text for which it is cited, i.e., that drugstores carry more drugs than hospital pharmacies. It states that the average hospital pharmacy stocks 5,000-8,000 items. This is in excess of the average drugstore inventory of about 3,000, as stated by respondent. The same article states that a hospital pharmacy inventory is not limited to the institution's formulary.

FILED
DEC 6 1975
MICHAEL RODAK, JR., CLERK

No. 74-1274

In the Supreme Court

of the United States

OCTOBER TERM, 1975

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

RESPONDENT'S SUPPLEMENTAL BRIEF

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PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

RESPONDENT'S SUPPLEMENTAL BRIEF

Pursuant to Rule 41.5, Respondent submits the following late authorities and other intervening mat-

ters that were not available in time to have been included in respondent's brief in chief.

PLAINTIFF'S NOV. 6, 1975 HARTMAN AFFIDAVIT RE NEW KAISER HOSPITAL SEPARATE INPATIENT AND OUTPATIENT PHARMACIES, p. 4, infra.

PLAINTIFF'S NOV. 7, 1975 HARTMAN AFFIDAVIT RE SANDOZ PHARMACEUTICALS CONTRACT RESTRICTIONS ON DRUG USE, p. 7, infra.

AFFIDAVIT OF ROGER TILBURY, p. 10, infra.

"Economic Problems of Small Business in the United States," Senate Select Committee on Small Business, 94th Congress, First Session, Hearing on economic problems of small business in Oregon and the Pacific Northwest, Portland, Oregon, August 26, 1975; pp. 64-204, Statement of Henry Kane, Attorney, on behalf of the Portland Retail Druggists Association, Inc., accompanied by Stanley E. Hartman, President-Elect, Portland Retail Druggists Association, Inc.

International Telephone and Telegraph Corporation v. *General Telephone & Electronics Corporation*, 518 F.2d 913, 935 (9th Cir. 1975) held:

"Pertinent Supreme Court decisions require that a line be drawn with painstaking care be-

tween exempt and nonexempt activity.[82] If an activity is nonexempt, the antitrust laws apply with undiminished force, whether or not the activity is regulated.[83] * * * The 'advantages' flowing from the challenged activity and purportedly fostered by the regulatory scheme become as irrelevant as they would be in the absence of any regulation whatsoever. A contrary rule would eviscerate in piecemeal fashion the Supreme Court's doctrine that 'repeals by implication [of the antitrust laws] are not favored. Only a clear repugnancy between the old law and the new results in the former giving way and then only *pro tanto* to the extent of the repugnancy * * *.' Georgia v. Pennsylvania R. Co., 324 U.S. 439, 456-57, 65 S.Ct. 716, 726, 89 L.Ed. 1051 (1945).[84]

United States v. *M.P.M., Inc.*, 397 F. Supp. 78, 86, fn. 5 (D. Colo. 1975) held that four per cent was not "*de minimis*:"

"5. Parenthetically, we observe that even if the 4% figure were established by credible evidence we would not regard it as *di minimis* for jurisdictional purposes."

Respectfully submitted,

ROGER TILBURY
HENRY KANE
Attorneys for Respondent

"[82] *See, e.g.*, Georgia v. Pennsylvania R. Co., 324 U.S. 439, 456-457, 65 S.Ct. 716, 89 L.Ed. 1051 (1945)."
"[83] *See, e.g.*, Otter Tail Power Co. v. United States, 410 U.S. at 372, 93 S.Ct. 1022.
"[84] *See also* Silver v. New York Stock Exchange, 373 U.S. 341, 357, 83 S.Ct. 1246, 10 L.Ed.2d 389 (1963)."

United States District Court for the District of Oregon

PLAINTIFF'S NOV. 6, 1975 HARTMAN AFFIDAVIT RE NEW KAISER HOSPITAL SEPARATE INPATIENT AND OUTPATIENT PHARMACIES

(Filed November 6, 1975; caption omitted in printing)

I, Stanley E. Hartman, being first duly sworn, depose and say:

1. I am the President of the Portland Retail Druggists Association, Inc., plaintiff herein, a registered pharmacist licensed to practice pharmacy in the State of Oregon, make this affidavit on my personal knowledge, attended various of the depositions of hospital officials taken by plaintiff herein, am familiar with the trial court file, and make this affidavit pursuant to F.R.Civ.P. Rule 56.

2. In September of 1975, I took part in a guided tour of the new Kaiser Foundation hospital located at 10180 S.E. Sunnyside Road, Clackamas, Oregon 97015. At each department the tour guide would turn the group over to a spokesman for the particular department.

2. At the "outpatient" pharmacy in the public section of the Kaiser Sunnyside Medical Center, a Kaiser pharmacist explained that the hospital had two pharmacies, one for outpatients and the second for hospitalized inpatients.

3. The pharmacist also said that the new hospital was the first one west of the Mississippi to use exclu-

sively the "unit dose" system of drug dispensing to hospitalized patients.

4. The "unit dose" system of drug dispensing is the practice of packaging drugs in individual units or containers for administration to the patient at one time. The traditional packaging method is the multi-unit drug container which the Kaiser outpatient clinic uses for drug consumption away from the hospital premises.

5. Exhibit A to this affidavit is the front and back of pharmacy license # 00649 the Oregon Board of Pharmacy issued September 5, 1975 to the Kaiser Sunnyside Medical Center outpatient pharmacy ("OPD").

6. Exhibit B to this affidavit is the front and back of pharmacy license # 00650 the Oregon Board of Pharmacy issued September 5, 1975 to the Kaiser Sunnyside Medical Center inpatient pharmacy ("Inpt.").

7. Exhibit A and Exhibit B are certified as true and correct by A. G. "Mike" McLain, Oregon Board of Pharmacy Secretary-Treasurer. I certify that Exhibit A and Exhibit B to this affidavit are the true and correct certified copies the plaintiff received from Mr. McLain.

8. Kaiser's two separate pharmacies lay to rest unsupported allegations that affirmance of *Portland Retail Druggists Association, Inc.* v. *Abbott Laboratories*, et al, 510 F.2d 486 (9th Cir. 1974) would ham-

per receipt of 15 U.S.C. § 13c price discounts by eligible hospitals.

9. Opening of the two separate Kaiser pharmacies is evidence that an eligible hospital can continue to receive 15 U.S.C. § 13c price benefits for drugs dispensed within the eligible hospital. It can do so by designating one hospital for inpatient drug dispensing and another pharmacy for drug dispensing outside the § 13c exemption.

10. The reference to Kaiser is not meant to imply that Kaiser is entitled to the § 13c exemption on drug and other purchases. Kaiser is not entitled to the § 13c exemption.

(Subscription, jurat, and certificate of service omitted in printing)

[See exhibits in pocket folder]

United States District Court for the District of Oregon

PLAINTIFF'S NOV. 7, 1975 HARTMAN AFFIDAVIT RE SANDOZ PHARMACEUTICALS CONTRACT RESTRICTIONS ON DRUG USE

(Filed November 7, 1975; caption omitted in printing)

I, STANLEY E. HARTMAN, being first duly sworn, depose and say:

1. I am the President of the Portland Retail Druggists Association, Inc., plaintiff herein, a registered pharmacist licensed to practice pharmacy in the State of Oregon, make this affidavit on my personal knowledge, am familiar with the trial court file, and make this affidavit pursuant to F.R.Civ.P. Rule 56.

2. Exhibit A to this affidavit is a true and complete copy of the Sandoz Pharmaceuticals APPLICATION FOR INSTITUTIONAL ACCOUNT FORM, identified as DD-13, and indicating that it was revised "7/75."

3. Exhibit A is similar to a prior notice that is part of the trial court file that provided that drugs purchased from Sandoz Pharmaceuticals were to be consumed within the institution.

4. Exhibit A states in part under the heading of "2. *Certification*":

"* * * It is agreed that:

"a. All products purchased will be properly stored and dispensed exclusively within the confines of the purchasing agency and/or institution, or its satellite dispensing facili-

ties, and *used exclusively in prescriptions for patients of the agency and/or institution specified above*, or the patients of any of its satellite dispensing facilities.

"b. Satellite facilities referred to above, if any, *are wholly owned and operated by the institution.*

"c. *No products purchased from Sandoz will be resold by the agency and/or institution*, or its satellite dispensing facilities, to any other reseller of drugs—wholesaler, retailer, hospital, physician, nursing home, clinic, or any other category. * * *"
(emphasis by Sandoz Pharmaceuticals)

5. The key words include:

"* * * *dispensed exclusively within the confines* of the purchasing agency and/or institution, or its satellite dispensing facilities, *and used exclusively for patients* of the agency * * *" (emphasis added)

6. The key words also include in subparagraph c:

"No products purchased from Sandoz will be resold * * * to any other reseller of drugs— * * * *physician*, * * * *clinic or any other category.*"

7. Sandoz therefore requires the drugs to be consumed by patients within the hospital or hospital clinic and by definition excludes physicians, staff employees and any others who are not patients who consume the drug within the hospital. Resale is forbidden to, among others, physicians and clinics.

8. Exhibit A is in accord with *Portland Retail Druggists Association, Inc.* v. *Abbott Laboratories*, et al, 510 F.2d 486 (9th Cir. 1974), U.S. Sup. Ct. Dkt. 74-1274, with respect to the distinction for purposes of 15 U.S.C. § 13c between drug consumption within the hospital and hospital clinics by patients and consumption away from the hospital and hospital clinic by physicians, hospital employees and others who are not patients.

(Subscription, jurat, and certificate of service omitted in printing)

[See exhibit in pocket folder]

AFFIDAVIT OF ROGER TILBURY

United States District Court for the District of Oregon

(Filed December 3, 1975; caption omitted in printing)

I, Roger Tilbury, being first duly sworn, on oath, depose and say as follows:

I am one of the attorneys for plaintiff.

We have just received the reply brief of defendants, which they have filed in the U. S. Supreme Court.

Among other misstatements and distortions which appear in such brief is the following comment in criticism of plaintiff's brief: (Reply Brief, 18-19)

> "Footnote 105: The current (1975) Portland telephone directory does not support the statement in the text for which it is cited, i.e., that drugstore service (including delivery service) is widely available in Portland 24 hours a day. It shows that nearly all drugstores operate only during regular business hours or in the early evening, and most are closed on week-ends or Sundays. Out of 211 listings for the Portland-Burlington-Lake Oswego-Milwaukie area, only six advertise after-hours emergency service."

The actual statement which defendant unfairly criticizes in our brief is as follows: (Respondent's Brief, 56)

> "Respondent's (PRDA) drug store assignors and other neighborhood pharmacies provide prescription delivery service (Meek's Rexall Powell Pharmacy), mail order service (Mt. Scott Pharmacy) and seven-day-a-week, 24-hour after-hours emergency service.[105]."

(Footnote 105 cites R. 646 and Portland Telephone Directory 851-2 [1975].

Defendants ignore the Record citation 646, which is a portion of an affidavit of Stanley E. Hartman, which reads:

> "On March 7, 1973, the plaintiff mailed a questionnaire to 50 independent pharmacies in the Portland area and received 32 replies. All 32 had provisions for emergency pharmacy service and 31 said they delivered prescriptions."

This affidavit was never challenged or contradicted by defendants—nor could it be.

Further, their statement regarding the telephone directory is inaccurate too. For example:

(a) there are not 211 listings of drugstores in the telephone book for Portland-Burlington-Lake Oswego-Milwaukie area. Rather, there are 152.*

> True copies of the pertinent pages of the telephone book are attached as Exhibit A. (Perhaps the defendants' confusion is due to the fact that some drugstores are listed more than once.)

(b) It is true that only six specifically mention

---

* 7 of those shown in the 1975 directory (Baza'r on SW 110th, Cole's, Errol Heights, Kaegi on S. E. Belmont[,] Labor Center, and Paige's have closed since the publication of the telephone directory, as well as Barnes Road Pharmacy.

after-hours emergency service. However, almost all provide such service, though not all advertise as the above quote from the record (R. 646) reveals. Moreover, even if one confined his search to these pages of the telephone book, it will be seen that 37 drugstores advertise home delivery service.

(c) The telephone book also reveals that 28 of the drug stores which are listed indicate in the directory that they are open on Sunday or advertise 24-hour service.

I know of my own knowledge that there are other pharmacies which do make deliveries to customers but do not advertise this fact in the telephone directory.

(Subscription, jurat, and certificate of service omitted in printing)

[See exhibits in pocket folder which are reproduced with the permission of Pacific Northwest Bell Telephone Co.]

BEST COPY AVAILABLE

STATE OF OREGON
BOARD OF
PHARMACY
707 STATE OFFICE BLDG
LAND, OREGON 97201

APPLICATION FOR PHARMACY LICENSE AND PROPHYLACTIC LICENSE

722-75-0341 [S] [X] $25.00 APPLICATION
722-75-0342 [S] [X] $05.00
copy 2

#00649

▼ ATTACH STORE LABEL HERE ▼

Kaiser Foundation Hospitals - Oregon Region (OPD)
10180 S. E. Sunnyside Road
Clackamas, OR 97015

EXHIBIT A

ISSUED
SEP 5 1975
NOTED IN DATA PROCESSING

IMPORTANT: THIS IS YOUR APPLICATION FOR YOUR PHARMACY AND PROPHYLACTIC LICENSE. THIS APPLICATION MUST BE COMPLETED AND RETURNED WITH REMITTANCE OF THE PROPER FEE.

IF THIS IS FIRST APPLICATION FOR A LICENSE OR IF ABOVE INFORMATION IS INCORRECT—ENTER CORRECT DATA HERE

IF THERE HAS BEEN A CHANGE OF OWNER—ENTER NAME OF NEW OWNER

EXACT DATE OWNERSHIP CHANGED

IF THERE IS A CHANGE IN BUSINESS LOCATION—ENTER ADDRESS OF NEW LOCATION
Additional location - to open September 8, 1975

EXACT DATE OF MOVE

IF THERE HAS BEEN A CHANGE IN MANAGER—ENTER NAME OF NEW MANAGER

EXACT DATE OF CHANGE

CHANGE OF OWNER OR LOCATION REQUIRES INSPECTION AND APPROVAL BY THE BOARD
NEW STORES REQUIRE 30 DAY FILING PERIOD PRIOR TO INSPECTION

DATE STORE READY FOR INSPECTION
September 2, 1975

(EFF. 7/1/67)
FEES:
(CHECK APPROPRIATE BOX OR BOXES)

[X] PHARMACY LICENSE $25.00
[X] $25.00 PENALTY FEE FOR FEES RECEIVED AFTER JANUARY 1.
RETAIL PROPHYLACTIC LICENSE . . $ 5.00

TOTAL AMOUNT ENCLOSED
$30.00

HOW IS BUSINESS ORGANIZED

[ ] INDIVIDUAL OWNER, TRUSTEE, OR RECEIVER (ENTER NAME, TITLE, ADDRESS BELOW)
[ ] PARTNERSHIP (LIST NAME—ADDRESS OF ALL PARTNERS BELOW)
[X] CORPORATION (LIST NAME AND ADDRESS OF PRESIDENT, VICE PRESIDENT, SECRETARY, TREASURER BELOW)

NAME	TITLE	MAILING ADDRESS
J. A. Vohs	President	Ordway Building, Kaiser Center Oakland, CA 94666
Scott Fleming	Sr. VP & Reg. Mgr.	1500 S. W. First Ave., Portland, OR 97201
R. A. Scott	Reg. Contr.	1500 S. W. First Ave., Portland, OR 97201
R. J. Erickson	Sr. VP & Secretary	Ordway Building, Kaiser Center Oakland, CA 94666

ASSUMED BUSINESS NAME—IF ANY

DATE CORPORATION ORGANIZED—IF NEW

STATE IN WHICH INCORPORATED

LIST ALL REGISTERED PHARMACISTS EMPLOYED—(INCLUDE ANY REGISTERED ASSISTANT PHARMACISTS)

REGULAR EMPLOYEE (NAME)	CERTIFICATE NUMBER	IS CERTIFICATE DISPLAYED?	TEMPORARY RELIEF, INTERN EMPLOYEE (NAME)	CERTIFICATE NUMBER	IS CERTIFICATE DISPLAYED?
Dan Gandera	4986	Yes			
			441- 22.130	25	
			22.480	5	

HRS. DAYS STORE OPEN
9 AM TO 5 PM Mon. THROUGH Sat.

REGISTERED PHARMACISTS IN CHARGE OF STORE AT ALL TIMES? IF NO, EXPLAIN
[X] YES [ ] NO

ALL PHARMACISTS CERTIFICATES MUST BE DISPLAYED PROMINENTLY

Page 4 - EX. A

MAKE ALL REMITTANCES PAYABLE TO
OREGON STATE BOARD OF PHARMACY

ALL APPLICANTS MUST COMPLETE THIS SECTION (CHECK APPROPRIATE BOXES)

1 DO YOU HAVE THIS EQUIPMENT?

[X] YES	[ ] NO	ONE BASE SCALE CAPABLE OF WEIGHING ½ GRAIN OR LESS
[X] YES	[ ] NO	ONE SET OF ACCURATE APOTHECARY WEIGHTS FROM ½ GRAIN TO 2 DRAMS
[X] YES	[ ] NO	ONE SET OF ACCURATE METRIC WEIGHTS FROM 50 MGS TO 20 GMS
[X] YES	[ ] NO	ALL OTHER EQUIPMENT AND STOCK PER MINIMUM EQUIPMENT LIST

2 ARE THESE PUBLICATIONS ON HAND?

[X] YES	[ ] NO	OFFICIAL POISON REGISTER OF ORGON BOARD OF PHARMACY
[X] YES	[ ] NO	CURRENT REVISION OF U. S. PHARMACOPOEIA PLEASE ENTER OFFICIAL SERIAL NUMBER OF YOUR EDITION
[X] YES	[ ] NO	CURRENT EDITION OF NATIONAL FORMULARY PLEASE ENTER OFFICIAL SERIAL NUMBER OF YOUR EDITION
[X] YES	[ ] NO	CURRENT PHARMACY LAWS OF OREGON

ALL OF THE UNDERSIGNED HEREBY STATE THAT ALL THE INFORMATION CONTAINED IN THIS APPLICATION FOR A PHARMACY AND RETAIL PROPHYLACTIC LICENSE IS TRUE AND CORRECT, THAT THEY HAVE READ AND ARE FAMILIAR WITH THE PHARMACY LAW AND THE REGULATIONS OF THE OREGON BOARD OF PHARMACY AND THAT SUCH PROVISIONS OF THE LAW WILL BE FAITHFULLY OBSERVED

SIGNATURE	TITLE (OWNER, PARTNER, ETC.)	DATE
Scott Fleming	Senior Vice President and Regional Manager	August 20, 1975

THE UNDERSIGNED REGISTERED PHARMACIST HEREBY CERTIFIES THAT HE/SHE IS IN ACTIVE PERSONAL CHARGE OF THE DRUG STORE OR PHARMACY DEPARTMENT

SIGNATURE	CERT. NO.	DATE
Jesse Pate	4477	August 20, 1975

DURING MY ABSENCE, THE SAID DRUG STORE OR PHARMACY DEPARTMENT IS IN THE ACTIVE PERSONAL CHARGE OF THE UNDERSIGNED REGISTERED PHARMACIST

SIGNATURE	CERT. NO.	DATE

IF THERE IS A CHANGE IN OWNERSHIP, LOCATION OR MANAGEMENT, PERMIT AND LICENSE WILL BECOME NULL AND VOID AND A NEW APPLICATION MUST BE FILED

I certify that this is a true and correct copy of the original application on file in the office of the Board of Pharmacy.

A. G. "Mike" McLain
Secretary-Treasurer
Dated - November 4, 1975

Page 5 - EX. A

BEST COPY AVAILABLE

STATE OF OREGON
BOARD OF
PHARMACY
707 STATE OFFICE BLDG
PORTLAND, OREGON 97201

APPLICATION FOR PHARMACY LICENSE AND PROPHYLACTIC LICENSE

#00650

▼ ATTACH STORE LABEL HERE ▼

Kaiser Foundation Hospitals - Oregon Region (Inpt.)
10180 S. E. Sunnyside Road
Clackamas, OR 97015

EXHIBIT B

ISSUED SEP 5 1975

NOTED IN DATA PROCESSING

IMPORTANT: THIS IS YOUR APPLICATION FOR YOUR PHARMACY AND PROPHYLACTIC LICENSE. THIS APPLICATION MUST BE COMPLETED AND RETURNED WITH REMITTANCE OF THE PROPER FEE.

IF THIS IS FIRST APPLICATION FOR A LICENSE OR IF ABOVE INFORMATION IS INCORRECT—ENTER CORRECT DATA HERE

IF THERE HAS BEEN A CHANGE OF OWNER—ENTER NAME OF NEW OWNER — EXACT DATE OWNERSHIP CHANGED

IF THERE IS A CHANGE IN BUSINESS LOCATION—ENTER ADDRESS OF NEW LOCATION: Additional location - to open September 8, 1975 — EXACT DATE OF MOVE

IF THERE HAS BEEN A CHANGE IN MANAGER—ENTER NAME OF NEW MANAGER — EXACT DATE OF CHANGE

CHANGE OF OWNER OR LOCATION REQUIRES INSPECTION AND APPROVAL BY THE BOARD. NEW STORES REQUIRE 30 DAY FILING PERIOD PRIOR TO INSPECTION. — DATE STORE READY FOR INSPECTION: September 2, 1975

(EFF. 7/1/67)

FEES: (CHECK APPROPRIATE BOX OR BOXES)

- [X] PHARMACY LICENSE $25.00
- [X] $25.00 PENALTY FEE FOR FEES RECEIVED AFTER JANUARY 1.
- [X] RETAIL PROPHYLACTIC LICENSE . . $ 5.00

TOTAL AMOUNT ENCLOSED: $30.00 ✓

HOW IS BUSINESS ORGANIZED

- [ ] INDIVIDUAL OWNER, TRUSTEE, OR RECEIVER (ENTER NAME, TITLE, ADDRESS BELOW)
- [ ] PARTNERSHIP (LIST NAME—ADDRESS OF ALL PARTNERS BELOW)
- [X] CORPORATION (LIST NAME AND ADDRESS OF PRESIDENT, VICE PRESIDENT, SECRETARY, TREAS. USED BELOW.)

NAME	TITLE	MAILING ADDRESS
J. A. Vohs	President	Ordway Building, Kaiser Center Oakland, CA 94666
Scott Fleming	Sr. VP & Reg. Mgr.	1500 S. W. First Ave., Portland, OR 97201
R. A. Scott	Reg. Contr.	1500 S. W. First Ave., Portland, OR 97201
R. J. Erickson	Sr. VP & Secretary	Ordway Building, Kaiser Center Oakland, CA 94666

ASSUMED BUSINESS NAME—IF ANY | DATE CORPORATION ORGANIZED—IF NEW | STATE IN WHICH INCORPORATED: California

LIST ALL REGISTERED PHARMACISTS EMPLOYED—(INCLUDE ANY REGISTERED ASSISTANT PHARMACISTS)

REGULAR EMPLOYEE (NAME)	CERTIFICATE NUMBER	IS CERTIFICATE DISPLAYED?	TEMPORARY, RELIEF, INTERN EMPLOYEE (NAME)	CERTIFICATE NUMBER	IS CERTIFICATE DISPLAYED?
Susan McMullan	5694	Yes			
Charles Greason	4921	Yes			
			441-22.130 25		
			22.400 5		

HOURS - DAYS STORE OPEN: 9 AM TO 5 PM THROUGH 7 days/week

REGISTERED PHARMACIST IN CHARGE OF STORE AT ALL TIMES? IF NO, EXPLAIN: [X] YES [ ] NO

ALL PHARMACISTS CERTIFICATES MUST BE DISPLAYED PROMINENTLY

Page 6 - EX. B

MAKE ALL REMITTANCES PAYABLE TO
OREGON STATE BOARD OF PHARMACY

ALL APPLICANTS MUST COMPLETE THIS SECTION (CHECK APPROPRIATE BOXES)

1 DO YOU HAVE THIS EQUIPMENT?

[X] YES	[ ] NO	ONE BASE SCALE CAPABLE OF WEIGHING ½ GRAIN OR LESS
[X] YES	[ ] NO	ONE SET OF ACCURATE APOTHECARY WEIGHTS FROM ½ GRAIN TO 2 DRAMS
[X] YES	[ ] NO	ONE SET OF ACCURATE METRIC WEIGHTS FROM 50 MGS TO 20 GMS
[X] YES	[ ] NO	ALL OTHER EQUIPMENT AND STOCK PER MINIMUM EQUIPMENT LIST

2 ARE THESE PUBLICATIONS ON HAND?

[X] YES	[ ] NO	OFFICIAL POISON REGISTER OF OREGON BOARD OF PHARMACY
[X] YES	[ ] NO	CURRENT REVISION OF U. S. PHARMACOPOEIA — PLEASE ENTER OFFICIAL SERIAL NUMBER OF YOUR EDITION _____
[X] YES	[ ] NO	CURRENT EDITION OF NATIONAL FORMULARY — PLEASE ENTER OFFICIAL SERIAL NUMBER OF YOUR EDITION _____
[X] YES	[ ] NO	CURRENT PHARMACY LAWS OF OREGON

ALL OF THE UNDERSIGNED HEREBY STATE THAT ALL THE INFORMATION CONTAINED IN THIS APPLICATION FOR A PHARMACY AND RETAIL PROPHYLACTIC LICENSE IS TRUE AND CORRECT. THAT THEY HAVE READ AND ARE FAMILIAR WITH THE PHARMACY LAW AND THE REGULATIONS OF THE OREGON BOARD OF PHARMACY AND THAT SUCH PROVISIONS OF THE LAW WILL BE FAITHFULLY OBSERVED.

SIGNATURE	TITLE (OWNER, PARTNER, ETC.)	DATE
[signature]	Senior Vice President and Regional Manager	August 20, 1975

THE UNDERSIGNED REGISTERED PHARMACIST HEREBY CERTIFIES THAT HE/SHE IS IN ACTIVE PERSONAL CHARGE OF THE DRUG STORE OR PHARMACY DEPARTMENT.

SIGNATURE	CERT NO	DATE
[signature]	4477	August 20, 1975

DURING MY ABSENCE, THE SAID DRUG STORE OR PHARMACY DEPARTMENT IS IN THE ACTIVE PERSONAL CHARGE OF THE UNDERSIGNED REGISTERED PHARMACIST.

SIGNATURE	CERT NO	DATE

IF THERE IS A CHANGE IN OWNERSHIP, LOCATION OR MANAGEMENT, PERMIT AND LICENSE WILL BECOME NULL AND VOID AND A NEW APPLICATION MUST BE FILED.

I certify that this is a true and correct copy of the original application on file in the office of the Board of Pharmacy.

A. G. McLain
A. G. "Mike" McLain
Secretary-Treasurer
Dated - November 4, 1975

BP 7056 885

(Office use only)

APPLICATION FOR INSTITUTIONAL ACCOUNT

EXHIBIT A

	FIELD NAME		TRANS CODE	FIELD DATA
			15 16	17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42
SHIP TO:	SHIP TO CUST.	NAME	0 2	
		SPECIAL INSTRUCTIONS	0 3	
		STREET ADDRESS	0 4	
		CITY, STATE & ZIP CODE	0 5	ZIP CODE
BILL TO:	BILL TO CUST.	NAME	0 7	
		SPECIAL INSTRUCTIONS	0 8	
		STREET ADDRESS	0 9	
		CITY, STATE & ZIP CODE	1 0	ZIP CODE
	D. E. A. # (see note) Registration No.		1 6	*NOTE: Photocopy of the Pharmacy's Controlled Substances Registration Certificate MUST Accompany Application
	STATE LICENSE REGISTRATION NO.		1 7	
	TERRITORY NUMBER		1 3	Region / Spec. Dept. ← (Representative or Regional Manager use only.)
	SHIP TO: CITY, CNTY, STATE & ZIP		1 4	STATE / COUNTY / CITY / ZIP CODE ← (Office Use Only)
	CUSTOMER CLASS		1 5	← (Office Use Only)
	HOSPITAL CONTROL		2 6	TYPE CONTROL XX XX ← (Office Use Only)
	SALES TAX		1 9	X.XX % If not applicable enter Sales Tax exemption number:

1. **Classification of Institution**

a. [ ] **NON GOVERNMENTAL INSTITUTION** owned and operated:
[ ] Not For Profit [ ] For Profit

By: Corporation: _____
Individual: _____
Partnership: _____

If applicant institution's pharmacy service is not owned and operated by the applicant institution, fill in exact name and address of owner:
Name: _____
St. Address: _____
City, St., Zip: _____

b. [ ] **GOVERNMENTAL INSTITUTION** wholly owned and operated by:

_____
(Name of State, City or County)

2. **Certification**

As a matter of record, all sales transactions between Sandoz Pharmaceuticals and purchaser are in accord with Federal, state and local statutes governing the transfer, storage and dispensing of prescription drugs. The undersigned warrants that the purchasing institution and/or agency maintains a licensed, on-site pharmacy which is wholly owned and operated solely by and for the purchasing agency and/or institution specified above.
It is agreed that:

a. All products purchased will be properly stored and dispensed exclusively within the confines of the purchasing agency and/or institution, or its satellite dispensing facilities, and used exclusively in prescriptions for patients of the agency and/or institution specified above, or the patients of any of its satellite dispensing facilities.
b. Satellite facilities referred to above, if any, are wholly owned and operated by the institution;
c. No products purchased from Sandoz will be resold by the agency and/or institution, or its satellite dispensing facilities, to any other reseller of drugs--wholesaler, retailer, hospital, physician, nursing home, clinic or any other category.
d. The applicant institution is fully responsible for payment for all merchandise which it may purchase from Sandoz should a direct purchasing account result from this application.

DATE: _____ SIGNED: (for applicant institution): _____
NAME: (print or type) _____
TITLE: _____

Submitted by
Sandoz Representative: _____ Date: _____

DD-13
Rev. 7/75

Hollywood Aquarium

SALT WATER FISH
AQUARIUMS
SOLD - INSTALLED

COMPLETE PET SUPPLY CENTER
BIRDS - SMALL ANIMALS

2729 N.E. BROADWAY

281-0582

C.B.'S TROPICAL

FOR ALL YOUR AQUARIUM NEEDS

- Exotic Tropical Fish
- Complete Plant Selection
- Bulk Supplies
- Live Food
- Gift Certificates

OVER 175 AQUARIUMS

ALL GLASS AQUARIUMS

AQUARIUMS SET UP & MAINTAINED IN YOUR HOME OR OFFICE

MON - FRI 12-8
SAT 10-7
SUN 12-6

666-8086

AIR CONDITIONED

50 N.W. 2nd AV., GRESHAM

To Find an AUTHORIZED Sales and Service Dealer

When you want the "genuine" in a nationally-advertised product or service

LOOK IN THE

Yellow PAGES

They Tell *"Where to Buy It"*

LAST MINUTE SHOPPING?

Don't panic. Look where 92 million people find it fast each year. In the Yellow Pages.

The Yellow Pages

▶ Pet Shops–(Cont'd)

GLOBE TROPICALS

TROPICAL FISH
AQUARIUMS
ALL ACCESSORIES
PUPPIES—KITTENS
EXOTIC BIRDS

BankAmericard—Master Charge

Globe Tropical Aquarium & Pet Shop
4641 NE Fremont 284-4309

Hansen's Poodle Parlor
3822 NE Sandy Bv 287-7327

HOLLAND FEED PET & GARDEN SUPPLY
12250 SW Broadway
Beaverton 644-3400

Hollywood Aquarium & Pets
2729 NE Broadway 281-0582
(Please See Advertisement This Page)

HOLLYWOOD POODLE PARLOR
4615 NE Sandy Bv 288-4718

Jari's Dog Boutique
7927 SE 13th 233-1967

King Neptune's Aquarium & Pets
4500 SE Woodstock Bv 774-3919
(Please See Advertisement Page 848)

LAKE GROVE GARDEN CENTER
15955 SW Boones Ferry
Rd (LG) 636-2414

Lake Oswego Dog Shoppe
356 N State (LO) 636-9344

LOMBARD PET AND SUPPLY
4772 A N Lombard 289-3463

Pet Bazaar
13235 SE McLoughlin Bv
Milwaukie 654-0021

PET BOUTIQUE THE
4434 NE 131st Pl 252-2102

PET 'N' POND
14405 SW Pacific Hwy (T) 620-1226
(Please See Advertisement Page 849)

Pied Piper Pet Palace
1653 Jantzen Beach Center 289-1685
(Please See Advertisement Page 849)

PORTLAND GARDEN & PET CENTER
204 SW Yamhill 228-3871
(Please See Advertisement Page 849)

SCAMP'S PET CENTER
320 Gresham Mall (G) 666-8300

Shari's Dog Shop 4745 SW 77th 292-6651

Southgate Ace Hardware Co
10335 SE 82d 771-2607

SOUTHGATE TROPICALS
10425 SE 82d 774-9177
(Please See Advertisement Page 849)

Tom's Aquarium
Located Just Off 66th & Sandy Bv
200 Varieties To Select From
Open 1 PM-8:30 PM Closed Thursdays
3219 NE 66 Av 288-3944

Topper's 11714 SE Stark 254-5918

TROPICAL FISH EMPORIUM

S.W. AREA

Over 15 Years Experience

4100 SW Cedar Hills Bv
Beav 644-2881

TROPICAL HUT THE
220 NE 4th Gresh 666-3127

Tucker Leather Goods
9003 SE Stark 252-5595

Pet Supplies–Retail

—See Pet Shops

Pet Supplies–Whsle & Mfrs

—See Pet Shop Supplies

▶ Pet Transporting

Pet Ambulance Service
6300 NE 42d 281-3861

Petroleum Equipment

—See Service Station Equipment

▶ Petroleum Products

ARCO Atlantic Richfield Co
2145 NE Union 282-7763

Charter Energy Company
7900 NW St Helens Rd 286-2819

Collins Oil Co 3326 NW 35th 285-4555

Columbia Independent Refinery Inc
200 SW Market 227-5698

Gull Oil Co 252-3979

MOLY LUBRICANTS—
OIL FILTER SERVICE CO
615 SE Market 232-5126

Priestley Chet Heating Oils
5418 SE Mitchell 774-2205

PRIESTLEY OIL AND CHEMICAL CO

DISTRIBUTOR

Standard Oil Co. of Calif. Products

LUBRICATING OILS
KEROSENE—SOLVENTS
PAINT & LACQUER THINNERS
CHEVRON HEATING FUELS

2429 N Borthwick 288-5294

▶ Pharmaceutical Products–Whsle & Mfrs

Burgin-Arden Inc
18220 NE San Rafael 666-7740
Or 666-9523

Highland Laboratories Inc
Custom Vitamin Tableting & Capsulating-Wholesale Only
3379 SE Division 233-7786

Kirkman Laboratories Inc
934 NE 25th 233-4441

LEDERLE LABORATORIES DIVISION AMERICAN CYANAMID CO
3145 NW Yeon 228-6281

Matteson Glenn Co Inc The
Food Supplements-Manufacturers-Whsle Only
1875 SE Belmont 234-7391

Merck Sharp & Dohme Div Of Merck & Co Inc 717 NE Lombard 285-2582

OLSHEN'S BOTTLE SUPPLY CO
1204 SE Water 233-5049

Pacemaker Corp 9943 E Burnside 252-0208

Pfizer Inc 3333 NW Industrial 222-9281

Ross Laboratories
2030½ NW Terminal 248-0193

STANLABS INC 232 SE Oak 234-0432

STANLEY DRUG PRODUCTS INC
232 SE Oak 234-0432

UPJOHN CO 1333 NE Union Av 236-2133

▶ Pharmacies

Affleck's Pharmacy
2222 NW Lovejoy 227-1294

Affleck's 25th&Lovejoy Medical Bg Pharmacy 2525 NW Lovejoy 227-2524

AINSWORTH PHARMACY
3002 NE Ainsworth 282-0787

ALBERTA PHARMACY
YOUR NEIGHBORHOOD REXALL STORE
Prescriptions — Delivery
Fountain Service
"Attractive Gifts & Greeting Cards"
Utility Pay Station
Water, Gas & Pacific Power
2403 NE Alberta 281-8717

ALLEN'S RALEIGH HILLS REXALL DRUG

RALEIGH HILLS

Free Prescription Delivery

7306 SW Beaverton
Hillsdale Hy 292-3539

ALLRED'S DOWNTOWN DRUG STORE
(Formerly Heathman Hotel Drugs)
50 YEARS
IN DOWNTOWN PORTLAND
Prescriptions-Gifts-Souvenirs
Free Downtown Rx Delivery
1003 SW Broadway 228-6379

Baker Drug Co 25 NW 3d Av 222-1208

BALES PHARMACY
Milltowner Shopping Center 644-2178

Barnes Road Professional Pharmacy
9340 SW Barnes Rd 297-1461

BAZA'R

BAZAAR

24 HR ANSWERING SERVICE

PORTLAND
Baza'r Inc 2315 SE 82d 774-1111

BEAVERTON
Baza'r Inc 4401 SW 110 646-7169

Baza'r Inc 2315 SE 82d 774-1111

BEAVERTON PHARMACY

BEAVERTON

Prescriptions Our Specialty

OPEN 7 DAYS A WEEK

Hollister Ostomy Products

Sundries—Cosmetics—Photo Finishing

Always Plenty of Parking

BANKAMERICARD & Master Charge Welcome

12475 SW Broadway (B) 644-2101

Continued Next Page

Simplify your buying—know where to buy it. The dealers in many nationally advertised articles are listed in the Yellow Pages. Make it a habit to "Look inside the Yellow Pages" before buying.

Would you like a separate business listing under your own name in the Telephone Directory? Does anyone in your business or home wish a personal listing? The charge for extra listings is small, the convenience often great.

Wise buyers say there's nothing like the Yellow Pages of your telephone book for getting in touch with almost everyone around who sells things, fixes things, does things. Try them ... you'll use them often.

Pharmacies–(Cont'd)

BEL AIRE PHARMACY
12020 SW Allen (B) 646-2129

Bowman Pharmacy
2400 SW Vermont 246-3754

Broadwill Pharmacy Inc
306 NE 28th 236-4481

BROOKLYN REXALL PHARMACY INC
Mon-Fri 8 am-9 pm & Sat 9 am-7 pm
4 Blocks South of Powell Blvd
PRESCRIPTION SPECIALISTS
Pay Station for All Utilities
CASCADE HEALTHCARE MEMBER
S&H Green Stamps
Photo Finishing—Cosmetics
"Free Prescription Delivery"
3370 SE Milwaukie 234-3488
Or 234-8348

Brooklyn Rexall Pharmacy Inc
3370 SE Milwaukie 234-8348

CAL'S PHARMACY
S&H GREEN STAMPS
LOW DISCOUNT PRICES
BANKAMERICARD—Master Charge
FREE DELIVERY SERVICE
Fountain Service
1 SE 28th 233-5217

CAPITOL HIGHWAY REXALL DRUG
7834 SW Capitol Hy 244-0188

CENT-WISE DRUG CEDAR HILLS
CEDAR HILLS SHOPPING CENTER
Open
7 Days a Week
10170 SW Park Wy 292-3574

CENTRAL DISCOUNT DRUG CO
538 SW 4th 226-4131
(Please See Advertisement This Page)

Century Discount Center
13525 NW Cornell Rd 646-3129

COLE'S DRUGS
10240 NE Halsey 253-1176
(Please See Advertisement Page 852)

Collins Pharmacy
5011 SE Hawthorne Bv 235-8597

Colonial Drug The
Open 9 AM-10 PM
16030 SE Stark 255-0971

Convalescent Pharmaceutical Center
4805 SW Oleson Rd 297-1221

COOK'S TIGARD PHARMACY
PRESCRIPTION DELIVERY
PAM & JOHN COOK—OWNERS
16 YEARS IN TIGARD
OPEN 9 AM TO 7 PM
CLOSED SUN. & HOLIDAYS
AMPLE FREE PARKING
BANKAMERICARD & MASTER CHARGE WELCOME
LOC. IN CANTERBURY SQUARE
14315 SW Pacific Hy (T) 639-2181

Continued Next Column

The Yellow Pages place your name and telephone number before the buyer at the very moment he wants what you have to sell.

CORNER DRUG STORE
LOCATED ON PORTLAND STATE UNIVERSITY CAMPUS
Daily Courtesy Prescription Delivery Service
CLOSED SUNDAYS
S & H GREEN STAMPS
921 SW Montgomery 226-4021

Cornwell's Drive-In Pharmacy
2407 Main Vancouver
Wa ..... Portland Tel No 283-2443

CURRIN'S FOR DRUGS
NORTH PORTLAND PRESCRIPTIONS
Hallmark-Rubinstein-Utilities-Gifts
Wayne Hatch—Pharmacist-Owner
"Delivery Service"
286-0207
8430 N Lombard 286-0207

D&L Drugs ..... See Fischer's D&L Drugs

Damascus Pharmacy
19920 SE Highway 212
Damascus 658-3107

DAVIS DRUG CO
Serving Rose City Since 1923
Prescription Delivery at No Charge
We Give S&H Green Stamps
6052 NE Sandy Blvd 281-8319

DEAN'S REXALL DRUG
S&H GREEN STAMPS
IN BEAVERTON
12600 SW Farmington Rd
Beav 644-3181

Continued Next Page

Long distance doesn't cost—it Pays!

PRESCRIPTION HEADQUARTERS

NE CORNER OF 20th & E. BURNSIDE
• Trusses & Orthopedic Supplies Fitted By Trained Technicians
• Sick Room Supplies—Rent or Sell
• Diabetic Therapeutics
• OFFICIAL PAY STATION
TELEPHONE—GAS—ELECTRIC—WATER
"WE LOVE TO DELIVER"
234-9606
NEW LAURIE PHARMACY INC. DBA
Leton's Rexall

SINCE 1903
CENTRAL DISCOUNT DRUGS

BOB HELDFOND
LET US QUOTE YOU PRICES ON PRESCRIPTIONS
• Bring in any RX or Refill you wish transferred to Us
• Have your Doctor call us or We will call Him
• We Mail Prescriptions Overnite Service
• We fill Welfare & Blue Cross Prescriptions
• Vitamins
• Cosmetics
• Health Supports
CORNER 4th & ALDER DOWNTOWN 226-4131

MEEKS Rexall POWELL PHARMACY
PRESCRIPTION SPECIALISTS
3830 S.E. POWELL BV.
OPEN 9 A.M. to 9 P.M.
232-3188 232-7159
■ COSMETICS ■ SUNDRIES ■ CANDIES
■ WE COLLECT ALL UTILITIES
■ PRESCRIPTION DELIVERY SERVICE
EMERGENCY 234-2874 or 236-6270
CLOSED SUNDAYS

Codes in listings indicate communities as follows: (B) Beaverton (Bur) Burlington (G) Gresham (LG) Lake Grove (LO) Lake Oswego (MO) Milw-Oak Gr (OC) Oregon City (T) Tigard

MT. SCOTT PHARMACY
SOUTHEAST DISTRICT
• GIFTS
• BABY NEEDS
• SUNDRIES
• JEWELRY
• PHOTO FINISHING
• CAMERAS
Travelers Express Money Orders
PRESCRIPTIONS
• We Fill Welfare Prescriptions
• BankAmericard
• Master Charge
• Blue Cross
• Paid Prescription Plan
• Cascade Health Care
• P.A.C.C.
• Prescription Plan Service We will bill your insurance company
771-9025 or 771-9026
AFTER HOURS CALL 760-1472
FREE DELIVERY & MAIL ORDER SERVICE
SICK ROOM SUPPLIES—SALES & RENTALS
UTILITY PAY STATION

LABOR CENTER PHARMACY
UNION MEMBERS & FRIENDS OF LABOR WELCOME
"ENJOY UNUSUAL SAVINGS"
PRICES QUOTED OVER THE PHONE
COMPARE OUR PRICES & SAVE!!!
ONE DAY MAIL ORDER SERVICE - ANYWHERE!
9 A.M. TO 5:30 P.M. WEEKDAYS
WE WILL CALL & TRANSFER YOUR PRESCRIPTION FOR YOU...
WE WILL ALSO CALL YOUR PHYSICIAN - OR HAVE HIM CALL US
We Fill PCS - PAID & Welfare Prescriptions
201 S.W. Arthur
IN THE LOBBY OF LABOR CENTER BLDG
224-6455

Cole's DRUGS
GATEWAY AREA PRESCRIPTIONS
GREETING CARDS, GIFTS
Fountain
Postal Sub-Station Utilities Pay Station
Have Your Oregon Coffee Direct
253-1176
10840 N.E. HALSEY

MILWAUKIE
SINCE 1914
PERRY PHARMACY
THE REXALL STORE
S & H GREEN STAMPS
UTILITY PAY STATION
9 A.M.-8 P.M. MON. THRU FRI.
9 A.M.-7 P.M. SAT.
LOCATED DOWNTOWN MILWAUKIE
CORNER OF MAIN & MONROE
654-5434
1101 MAIN (MO)

PCC PORTLAND CENTER PHARMACY
SERVICE IS OUR SPECIALTY
• Prescription Specialists
• Exclusive Cosmetics
• Gifts you are proud to give and would love to receive
Open 10 to 6 Daily Saturday 10 to 2
ED CALDWELL REG PH—OWNER
223-1975
OR 222-1261
RUSSELL STOVER CANDY
1975 S.W. 1st
Ample Free Parking

PROFESSIONAL PLAZA 102
Pharmacy
PRESCRIPTIONS DELIVERED
Participating In
BLUE CROSS—PCS & PAID PRESCRIPTION PLANS
OPEN 9 TO 7 MON. FRI
9 TO 6 SAT.
254-7383
PROFESSIONAL PLAZA
102 PHARMACY
1286 N.E. 102nd AVE

SINCE 1[illegible]
5 REGISTERED PHARMACISTS
• CRUTCHES & WHEEL CHAIRS - SALES & RENTAL
• ELASTIC STOCKINGS & SUPPORTS
• COSMETICS
• PHOTO & CAMERA DEPT
• UTILITY PAY STATION - GAS LIGHTS - PHONE - WATER
OPEN 8AM to 10PM SUNDAYS - OPEN 10AM
MONEY ORDERS TOO
PRESCRIPTION (DELIVERY SERVICE)
Baker Square
774-3839
8828 S.E. FOSTER RD.

SOUTHWEST Portland-Beaverton
West Slope Pharmacy
Since 1939
Hallmark Cards
Prescriptions You Can Afford
Senior Citizen Discounts
Charge Accounts - Deliveries
Open 9 - 6 Daily Sat. 9 - 5
292-3551
8745 SW CANYON LN

THRIFTY DRUGS
(LEVETON THRIFTY DRUGS)
PRESCRIPTIONS
FREE DELIVERY & MAIL ORDERS
PHOTO FINISHING
MONEY ORDERS
GIFTS•COSMETICS•BABY NEEDS & CRUTCH RENTALS
HUDSON VITAMINS
MEMBER BLUE CROSS PRESCRIPTION DRUG PROGRAM
235-2106
8201 SE 17TH
SELLWOOD - MORELAND
9 A.M.-10 P.M. WEEKDAYS 13-6 SUN. & HOL.

OAK GROVE PHARMACY
PRESCRIPTION SPECIALIST
DELIVERY SERVICE
HALLMARK CARDS - COSMETICS
GIFTS FOR ALL OCCASIONS
FOUNTAIN & BAR SUPPLIES
FOR YOUR HOME
LUNCH COUNTER
OAK GROVE
MILWAUKIE
654-2111
2111 SE OAK GROVE BV

Pharmacies–(Cont'd)

DICKSON DRUG CO INC
Montavilla Since 1910
Prescriptions—Free Delivery
Utility Pay Station—Postal Sta. #5
7937 SE Stark 254-5595

DISCO MART DISCOUNT SHOPPING CENTER
TWO PHARMACIES TO SERVE YOU
MILWAUKIE OAK GROVE AREA
SE 42d & King Rd 659-1840
SE WOODSTOCK BLVD
SE 45th & SE Woodstock Bv 777-3911

Disco Mart Discount Shopping Center Pharmacy
SE 45th & SE Woodstock Bv 777-3911
Pharmacy
4306 SE King Rd Milw 659-1840

ERROL HEIGHTS REXALL PHARMACY
S.E. 52nd & FLAVEL
PRESCRIPTIONS
Utilities Pay Station Post Office
Wheel Chairs & Crutches for Rent
Open 9:30 a.m. to 7 p.m. Closed Sun
BANKAMERICARD Welcome
7475 SE 52d 771-2872

Ever Ready Drug
4100 SE Division 235-6634

FAIRLEY'S PHARMACY INC
Prescription Headquarters
N.E. Portland Area
Sick Room & Diabetic Supplies
Crutches—Elastic Hosiery & Supports
Pay Sta. for Utilities—Money Orders
DELIVERY SERVICE
9 AM to 10 PM—Closed Sundays
Saturdays—9 AM to 9 PM
7206 NE Sandy Blvd 284-1159

FISCHER'S D & L DRUGS
N. LOMBARD AT DENVER
PRESCRIPTIONS A SPECIALTY
S&H Green Stamps
Prescription Delivery 4 PM to 6 PM
Money Orders—Cosmetics
Gifts—Baby Dept.—Photo Dept
Greeting Cards
9 AM to 6 PM Mon thru Sat
Giftomerica
1944 N Lombard 285-7995

Flanders Pharmacy
2330 NW Flndrs 228-4119

Continued Next Page

Buy through the Yellow Pages.

▶ Pharmacies–(Cont'd)

FOWLER WM DON
7935 NE Glisan ---- 253-1843
FOWLER'S DRUG SHOP
7935 NE Glisan ---- 253-1843
FRANKLIN REXALL DRUG
4848 SE Division ---- 235-1143

FRED MEYER INC
Highest Quality Pharmaceuticals
Fred Meyer
"JUST SAY CHARGE IT"
OPEN 9 A.M. TO 10 P.M.
Including Sundays
"WHERE TO CALL"
FRED MEYER
SUPER SHOPPING CENTERS

FRED MEYER INC
Beaverton
4800 SW Western Ave
Beav ---- 646-7158
Burlingame
7555 SW Barbur Bv ---- 246-8849
Division
SE 122d & Division ---- 761-3833
Fourth Plain
2201 Grand Bv Vancouver Wa ---- Portland # 285-6058
Gateway 10000 NE Halsey ---- 255-5494
Gilsan 6615 NE Gilsan ---- 234-6511
Hawthorne
3805 SE Hawthorne Bv ---- 234-7559
Hazel Dell
7700 Hy 99 Vancouver Wa ---- Portland # 289-9622
Hollywood
4161 NE Sandy Bv ---- 288-5559
Interstate 7404 N Interstate ---- 285-0221
King Road 10510 SE 82d ---- 777-1418
Morrison 436 SW Morrison ---- 226-6791
Oak Grove
14700 SE McLoughlin Bv
Milw ---- 659-2232
Peninsula 6850 N Lombard ---- 286-0629
Raleigh Hills
7700 SW Beaverton Hillsdale Hy ---- 292-3531
Rockwood 18535 SE Stark ---- 665-9156
Rose City
6939 NE Sandy Bv ---- 282-7229
Southeast 5253 SE 82d ---- 777-3359
Stadium 100 NW 20th ---- 226-7179
Stark 700 SE 122d ---- 256-1033
Tigard 11565 SW Pacific Hy ---- 639-3105
Walnut Park
5408 NE Union Av ---- 282-0938

Fred Meyer Inc
14700 SE McLoughlin Bv Milw ---- 659-2232

GARDEN HOME PHARMACY
For Our Regular Customers
We Have 24 Hour Prescription & Prescription Delivery Service
7405 SW Garden Home Rd ---- 246-1432

Geriatric Health Services Inc
2828 SW Corbett ---- 228-3101

GILMAN PHARMACY
ALAMEDA AREA
Fremont at N.E. 24th Ave.
A Complete Drug Shopping Center
Prescription Specialists
We Give S&H Green Stamps
FREE PRESCRIPTION DELIVERY IN THE AREA
10 AM to 6:30 PM Week Days
10 AM to 6 PM Saturday
3449 NE 24 Av ---- 282-2574

GOSS PHARMACY
5938 N Greeley Av ---- 285-7992

Continued Next Column

The Yellow Pages save you time

GRANT HIGH PHARMACY
Corner N.E. 33rd & Knott
GRANT HIGH AREA
Utility Pay Sta-Money Orders
9:00 to 9:00 Mon—Friday
9:00 to 7:00 Saturday
2647 NE 33d ---- 288-5261

GRESHAM MALL PHARMACY 666-1551
GRESHAM REXALL DRUG
5 E Powell Bv ---- 665-9191
HAMMEL'S PHARMACY
831 SW 11th ---- 226-2579

HEADLEY'S REXALL DRUGS
Hawthorne & SE 23rd
232-9151
HOURS 9 TO 9 MON-FRI
DELIVERY
AFTER HOURS EMERGENCY PRESCRIPTION SERVICE
Hollister Ostomy Products
PAY STATION
LIGHTS—TELEPHONE—GAS
WATER—MONEY ORDERS
2230 SE Hawthorne Bv ---- 232-9151

HEATHMAN HOTEL DRUGS—
See Allred's Downtown Drug Store

HILLSDALE PHARMACY
SOUTHWEST
PORTLAND
244-7582
OPEN 9-7 DAILY
SATURDAY 9-6
Prescriptions at Prices You Can Afford
Tax Records
Charge Accounts—Deliveries
Mail Service
6256 SW Capitol Hy ---- 244-7582

Hillsdale Pharmacy
6256 SW Capitol Hy ---- 244-7582

HOLLISTER OSTOMY PRODUCTS—
HEADLEY'S REXALL DRUGS
2230 SE Hawthorne Bv ---- 232-9151

HOLMES DRUG STORE
DEPENDABLE PRESCRIPTIONS
Pay Station—Tel. Lights Water & Gas
9 to 7 Mon thru Sat—Fine Toiletries
4506 SE Woodstock Blvd ---- 774-7857

IRVING ST PHARMACY
PRESCRIPTION SPECIALISTS
FREE DELIVERY
S&H GREEN STAMPS
9 am to 9 pm Sun 10 am to 6 pm
Let Us Price Your Prescriptions
638 NW 23 Av ---- 223-6297

KAEGI'S LAURELHURST PHARMACY
Prescription Specialists
Mon-Fri 9 AM-7 PM
Sat 9 AM-6 PM
Closed Sundays
Delivery and Utility Pay Station
Postal Sub Station
88TH & BELMONT
3811 SE Belmont ---- 233-3651

Kaegi's Pharmacy
Wilsonville Shopping Center
Wilsonville ---- 638-7878
Kern's For Drugs ---- See Currin's For Drugs
King City Pharmacy
King City Plaza Tigard ---- 639-5215
KING ROAD PHARMACY
4306 SE King Rd Milw ---- 659-1840

Continued Next Column

An extension telephone saves time and steps.

KITTLE'S METRO-EAST PHARMACY
Service Available-Money Orders
Blue Cross Participating
Located Next To Safeway
Halsey&122nd
12315 NE Halsey ---- 253-2998
LABOR CENTER PHARMACY
201 SW Arthur ---- 224-6455
(Please See Advertisement Page 852)
Lake Grove Pharmacy
16140 SW Bupres Ferry Rd (LO) ---- 636-5641
Lake Oswego Rexall Pharmacy
402 N State (LO) ---- 636-3611
Lakeside Drugs 464 SW 1st (LO) ---- 636-4593
LAURELHURST PHARMACY
3811 SE Belmont ---- 233-3651

LENTS REXALL PHARMACY
PRESCRIPTIONS DELIVERED
UTILITY PAY STATION
Personal Money Orders
9230 SE Foster Rd ---- 771-5041

LETON'S REXALL PHARMACY
2803 E Burnside ---- 234-9606
(Please See Advertisement Page 851)
LEVETON THRIFTY DRUG
Please See Advertisement Under Pharmacies
8201 SE 17th ---- 235-2106
LLOYD CENTER PHARMACY
1253 Lloyd Cntr ---- 282-2528
Logan Wallace Prescriptions
265 N Broadway ---- 284-7551
Lombard Drug—
See Fischer's D & L Drugs

MARY'S DRUG
In Hillsdale—By Poncho's
Mary Waletich—Owner
6325 SW Capitol Hy ---- 246-5441

McBAIN'S DRUG STORE
111 N Roberts Av Gresh ---- 665-4298
McCann's King City Pharmacy
King City Plaza Tigard ---- 639-5215
McGrew's Ainsworth Pharmacy
3002NEAnswrth ---- 282-0787

MEDIC PHARMACY INC
MAIL ORDER
Prescription Specialist
222-9611
"Prescriptions at a Savings"
9 am to 6 pm Monday thru Friday
Free Parking Under Building
SW 10th & CLAY
PORTLAND ORE. 97201
1016 SW Clay ---- 222-9611

Medic Pharmacy Inc
1016 SW Clay ---- 222-9611

MEDICAL ARTS PHARMACY
HYPO-ALLERGENIC COSMETICS
S&H Green Stamps—Delivery—Mail
Open 8:30-6:00—Sat 9:00-5:00
1016 SW Taylor ---- 223-2154

MEDICAL DENTAL BLDG PHARMACY
Allercreme Hypo-Allergenic Cosmetics
Lydia O'Leary Line—Covermark, Etc
Free Mail & Delivery Service
831 SW 11th ---- 222-9431

Medical Dental Bldg Pharmacy
831 SW 11th ---- 222-9431
MEEK'S REXALL POWELL PHARMACY
S & H Green Stamps
3830 SE Powell Bv ---- 232-3188
(Please See Advertisement Page 851)
Menlo Park Drug
12425 NE Glisan ---- 252-1413
METRO-EAST PHARMACY—
See Kittle's Metro-East Pharmacy

Continued Next Column

Please wait till you hear the dial tone ... then dial

MILWAUKIE PHARMACY
Since 1941
S.E. CORNER OF MAIN & MONROE
Lynn Schwalbe—Owner
Fast Prescription Service
Cosmetics—Soaps—Perfumes
Unusual Distinctive Gift Items
Health Food Products
Surgical Supports
Film Processing—Fountain
"BANKAMERICARD Welcome Here"
CLOSED SUNDAY
1102 Main Milw ---- 654-5413

MONARCH REXALL PHARMACY
Sellwood-Moreland
MILWAUKIE & BYBEE
SINCE 1935
Prescriptions
Cosmetics—Film Developing
Money Orders-Tri Met Tickets
Rx Delivery Service
236-4103
6910 SE Milwaukie ---- 236-4103

MOTE'S DRUG & GIFTS
LOW PRESCRIPTION PRICES
TIGARD
245 Tigard Shopping Plaza Tig ---- 639-1171

Mt Scott Pharmacy
9202 SE Foster Rd ---- 771-9025
(Please See Advertisement Page 852)
Mountain Park Pharmacy
4K SW Monroe Pkwy LkOs ---- 635-3651
MULTNOMAH REXALL DRUG
7834 SW Capitol Hy ---- 244-0188
NEW LAUREL PHARMACY
2803 E Burnside ---- 234-9606
Newhouse Pharmacy & Surgical
610 High (OC) ---- 656-7604

NOB HILL PHARMACY
Established 1892
PRESCRIPTIONS
Ask Your Doctor About Us
2100 NW Glisan ---- 227-1489

NOLAN REXALL DRUGS
WOODSTOCK
EASTMORELAND
HALLMARK CARD SHOP
COSMETICS—SUNDRIES
Prescription Delivery
774-1174
4030 SE Woodstock Blvd ---- 774-1174

Northrup Medical Center Pharmacy
2311 NW Northrup ---- 222-5715
OAK GROVE PHARMACY
2111 SE Oak Grove Bv
Milw ---- 654-2111
(Please See Advertisement Page 852)
Ogle Tom Prescriptions
4212 NE Brdwy ---- 282-1323
Oregon Geriatric Pharmacy
4805 SW Oleson Rd ---- 297-3024
Oswego Rexall Pharmacy
Prescription Delivery Service
402 N State (LO) ---- 636-3611

Continued Next Page

Telephone service is a friendly service.

Codes in listings indicate communities as follows: (B) Beaverton (Burl) Burlington (G) Gresham (LG) Lake Grove (LO) Lake Oswego (MO) Milw-Oak Gr (OC) Oregon C Ty (T) Tigard

▶ Pharmacies–(Cont'd)

OWL PHARMACY
DOWNTOWN
SW 10th & Washington
QUICK SERVICE
Open at 7:00 AM
Monday—Friday
935 SW Washington ---- 226-4121

Paige's Prescription Pharmacy
Open 10 AM-6 PM Monday Thru Saturday
Corner Of NE 7th&Knott
S & H Green Stamps
2701NE7Av ---- 284-4656
PARKROSE PHARMACY
10518 NE Sandy Bv ---- 253-8518

PAULSEN'S PHARMACY
PRESCRIPTIONS
43rd & Sandy—Hollywood District
S&H Green Stamps
4246 NE Sandy Blvd ---- 287-1163

Paulsen's Pharmacy
4246 NE Sandy Blvd ---- 287-1163
PAY LESS DRUG STORES NW
Stores
Gresham Hood Center
1555 NE Division Gresh ---- 666-9476
Jantzen Beach Shopping Center
1600 Jantzen Beach Center ---- 283-3178
Pay Less Plaza
105th & SE Washington ---- 252-1437
Portland Medical Center
501 SW 10th ---- 226-6644
Garrison Square
8000 E Mill Plain Bv Vancouver Wa ---- 206 695-3402
PAY'N SAVE DRUG STORES
Eastport Plaza
Retail Dept 4100 SE 82 Av ---- 775-6769
Prescription Dept 4100 SE 82 Av ---- 775-3266
Lloyd Center
Retail Dept 1421 Lloyd Center ---- 288-5901
Prescription Dept 1421 Lloyd Center ---- 280-4646
Bridgheswst
Retail Dept 6555 SW Beaverton Hillsdale Hy ---- 292-0135
Prescription Dept 6555 SW Beaverton Hillsdale Hy ---- 292-2671
PERRY PHARMACY
1101 Main (MO) ---- 654-5434
(Please See Advertisement Page 852)

PHIPPS PHARMACY
Open 10am-6pm Closed Sun & Holidays At North Beaver & Mississippi
4001 N Mississippi ---- 287-5007
Or ---- 287-5172

Phipps Pharmacy
4001 N Mississippi ---- 287-5172
PHOENIX REXALL DRUG INC
6828 SE Foster Rd ---- 774-3239
(Please See Advertisement Page 852)
PORTLAND CENTER PHARMACY
1975 SW 1st ---- 223-1975
Or ---- 222-1261
(Please See Advertisement Page 852)
Portsmouth Pharmacy
5279 N Lombard ---- 285-3616
Post Office Pharmacy
439 NW Brdwy ---- 227-2090
POWELL PHARMACY
S & H Green Stamps
3830 SEPowellBlvd ---- 232-3188
POWELLHURST REXALL DRUGS
3508 SE 122d ---- 761-4224
PROFESSIONAL PLAZA 102 PHARMACY 129-G NE 102d ---- 254-7383
(Please See Advertisement Page 852)
Providence Medical Bldg Pharmacy
545 NE 47th ---- 233-4969

Continued Next Column

Save Time by Using the "Yellow Pages."

RALEIGH HILLS REXALL DRUG
7306 SW Beaverton-Hillsdale Hy ---- 292-3539
REXALL DRUG PRODUCTS—
AINSWORTH PHARMACY
3002 NE Ainsworth ---- 282-0787
ALBERTA PHARMACY
2403 NE Alberta ---- 281-8717
BROOKLYN REXALL PHARMACY
INC 3370 SE Milwaukie ---- 234-3488
CAPITOL HIGHWAY REXALL
DRUG 7834 SW Capitol Hy ---- 244-0188
COLONIAL DRUG THE
16030 SE Stark ---- 255-0971
DAVIS DRUG CO
6852 NE Sandy Blvd ---- 281-8319
ERROL HEIGHTS REXALL PHARMACY 7475 SE 52d ---- 771-2872
FRANKLIN REXALL DRUG
4848 SE Division ---- 235-1143
GRESHAM REXALL DRUG
5 E Powell Bv ---- 665-9191
HEADLEY'S REXALL DRUGS
2230 SE Hawthorne Bv ---- 232-9151
KAEGI'S LAURELHURST PHARMACY
3811 SE Belmont ---- 233-3651
LENTS REXALL PHARMACY
9230 SE Foster Rd ---- 771-5041
LETON'S REXALL PHARMACY
2803 E Burnside ---- 234-9606
MEEK'S REXALL POWELL PHARMACY
3830 SE Powell Blvd ---- 232-3188
MONARCH REXALL PHARMACY
6910 SE Milwaukie ---- 236-4103
MULTNOMAH REXALL DRUG
7834 SW Capitol Hy ---- 244-0188
NOLAN REXALL DRUGS
4030 SE Woodstock Blvd ---- 774-1174
OSWEGO REXALL PHARMACY
402 N State (LO) ---- 636-3611
PERRY PHARMACY
1101 Main (MO) ---- 654-5434
PHIPPS PHARMACY
4001 N Mississippi ---- 287-5007
Or ---- 287-5172
PHOENIX REXALL DRUG INC
6828 SE Foster Rd ---- 774-3239
POWELLHURST REXALL DRUGS
3508 SE 122d ---- 761-4224
PROFESSIONAL PLAZA 102 PHARMACY
129-G NE 102d ---- 254-7383
RALEIGH HILLS REXALL DRUG
7306 SW Beaverton-Hillsdale Hy ---- 292-3539
ST JOHNS DRUG CO
8501 N Lombard ---- 286-0546
SAN RAFAEL REXALL DRUG
1914 NE 122 Av ---- 253-7513
SOUTHGATE REXALL DRUG & VARIETY 10317 SE 82d ---- 777-2271

Riggs Pharmacy
1049 Lloyd Center ---- 288-6326

ROBERTSON'S RALPH MT PARK PHARMACY
Prescription Specialists
Personal Record File
BAC & Charge Accts
Delivery & Mail Service
Emergency Service
Mon - Fri 10 AM-6 PM
Just Off Boones Ferry Rd—Lake Oswego
Ralph Robertson's Mountain Park Pharmacy
4K SW Monroe Pkwy LkOs ---- 635-3651

ROCKWOOD DRUGS
ROCKWOOD PLAZA
182nd & Division
PRESCRIPTIONS
Free Delivery Lunch Counter
GiftAmerica
We Specialize in All Insurance Plans
BANKAMERICARD/Master Charge
665-4184
2360 SE 182d Av ---- 665-4184

Rod's Pharmacy
1200 Portland Av Gladstone ---- 656-0873

Continued Next Column

ST JOHNS DRUG CO
REXALL-PRESCRIPTIONS
Cosmetics—Photo Finishing
Fountain Lunch
8501 N Lombard ---- 286-0546
Or ---- 286-0115

SAN RAFAEL REXALL DRUG
122nd & N.E. San Rafael
FREE DELIVERY
Blue Cross Participating
"We Give S & H Green Stamps"
1914 NE 122 Av ---- 253-7513

SEATON PHARMACY
SEATON Pharmacy
Since 1955
MT. TABOR AREA
Convalescent Supplies
Delivery Service
Store Entrance on Our New Parking Lot
Utility Pay Station
Post Office Substation
7 Days a Week 9 AM-9 PM
"FOR SERVICE CALL"
Seaton Pharmacy
5939 SE Belmont ---- 232-6171

Selling Bldg Pharmacy—
See Medical Arts Pharmacy
SKIDMORE PRESCRIPTION PHARMACY INC
740 SW Washington ---- 222-1701
SOUTHGATE REXALL DRUG & VARIETY 10317 SE 82d ---- 777-2271
Sylvan Clinic Pharmacy
5415 SW Westgate Dr ---- 297-3341
TEAMSTERS PHARMACY
1020 NE 3d ---- 233-8841
THE DRUG SHOP
7935 NE Glisan ---- 253-1843
THRIFTY DRUGS 8201 SE 17th ---- 235-2106
(Please See Advertisement Page 852)
TIGARD PHARMACY
Canterbury Square
See Ad Under Cook's Pharmacy
14315 SW Pacific Hy (T) ---- 639-2181

TOWN PHARMACY
PRESCRIPTIONS
Uptown Shopping Center
2334 W Brnsde ---- 226-6211

UNIVERSITY DRUG
4800 N Lombard ---- 289-5525
UPTOWN PHARMACY—
See Town Pharmacy
Village Drug
Lake Grove Shopping Center
SW Bryant & Boones Ferry Rd (LO) ---- 636-5697
Oswego Village Shopping Center
48 SW Village Ln (LO) ---- 636-3613
Village Square Drug—See Colonial Drug The

Continued Next Column

The Yellow Pages tell you where to buy the products and services you want. They also help you find the stores and trades people best fitted to supply your needs. Look in the Yellow Pages

Wallace Logan Prescriptions
265 N Broadway ---- 284-7551
WATSONS PHARMACY
SOUTHWEST
Prescription Service
Deliveries Available
UTILITY PAY STATION
HOME CARE PATIENT AIDS
Crutches—Canes—Wheelchairs, Etc
Store Hours
Mon thru Fri 9 AM-9 PM
Saturday 9 AM-6 PM
SW 19 Av & Barbur Blvd ---- 244-7553

West Linn Drugs
5639 NE Hood West Linn ---- 656-0306
West Slope Pharmacy
8745 SW Canyon Ln ---- 292-3551
(Please See Advertisement Page 852)
WESTMORELAND DRUG CO
PRESCRIPTIONS
WEST & EASTMORELAND
SELLWOOD DELIVERIES
7201 SE Milwaukie ---- 234-6519
WESTWOOD DRUG MART
S&H GREEN STAMPS
Open 9:00 to 9:00 Mon Thru Sat
10 AM to 6 PM Sun
7000 SE Thiessen Rd (MO) ---- 659-1150
WILSHIRE PHARMACY
N.E. 42 Between Fremont & Prescott
10 to 9 Mon-Sat S&H Green Stamps
Prescription & Emergency Del
4060 NE 42 Av ---- 288-1366
WOODLAWN PHARMACY
WE SPECIALIZE IN HEALTH
PAY STATION
FOR WATER & PHONE
PET & ANIMAL SUPPLIES
PHOTO FINISHING
6728 NE Union ---- 289-3312

Woodlawn Pharmacy
6728 NE Union ---- 289-3311

Phonograph Records
—See Records—Phonograph Headings

▶ Phonographs–Coin Operated

A & A AMUSEMENT CO INC
Serving the Northwest Since 1960
THE LATEST IN COIN OPERATED MUSIC—AMUSEMENT & VENDING MACHINES
Radio Dispatch Service
14324 SE Stark ---- 255-7206

A M I COIN OPERATED PHONOGRAPHS—
DISTRIBUTORS
ROWE INTERNATIONAL INC
309-9th N
Seattle Wa ---- 206 624-7594

AUTOMATIC CIGARETTE SERV
COIN OPERATED PHONOGRAPHS & VENDING MACHINES
Amusement & Cigarette Machines
Swan Island ---- 285-9161

Continued Next Page

Drug Sales to Patients, Outpatients, Physicians, Employes and the Public and Related Data Concerning Drug Distribution Practices of 14 Alleged "Nonprofit" Hospitals in Multnomah, Clackamas and Washington counties, State of Oregon:

Hospital	Time Period	Drug Sales by Period	Total Drug Sales	Cost of Drugs	Total Costs Charged to Drug Sales	Net Income From Drugs	Total Hospital Net Income From Drugs	Percentage of Profit on Drug Sales	Hospital Profit on Drug Sales	"Inpatient" and "Take-Home" Drug Sales	Total Hospital "Inpatient" and "Take-Home" Drug Sales	"Outpatient" and Other Drug Sales	Total "Outpatient" and Other Drug Sales	Employee, Family Drug Sales	Physician, Family Drug Sales	Total Physician, Employee Drug Sales	Number of "Outpatient" Prescriptions	Number of "Take-Home" Prescriptions	Number of "Employee" Prescriptions
Dwyer Memorial Hospital Milwaukie, Ore.	**Year ending** 6/30/1972	$ 278,023	$ 278,023	$	$ 156,907	$119,111	$ 119,111	42.84	42.84	$237,720	$ 237,720	$ 31,091	$ 31,091	$11,212 (est.)	$2,000 (est.)	$ 13,212			
Emanuel Hospital Portland, Ore.	**Calendar** 1966	568,871			296,976	300,895		52.89		551,949		16,922							
	1967	608,617			287,427	321,190		52.77		578,027		30,590							
	1968	668,949			382,752	216,913		32.43		624,027		44,733		44,922	(combined				
	1969	749,716			454,370	295,346		39.39		651,444		50,352		47,920	with				
	1970	800,076			523,356	276,720		34.59		682,852		59,116		53,129	employee				
	1971	881,880			598,946	282,934		32.08		723,014		73,662		60,481	sales)		21,650 (est.)		
	1972 (10 mos.)	836,855	5,114,964		553,590	283,265	1,977,263	33.84	41.2	692,634	4,503,947	59,391	334,766	56,857				25,500 (est.)	7,800 (est.)
Good Samaritan Hospital Portland, Ore.	**Year ending/'65** 6/30/1967	518,748			233,849	233,849		45.1		494,779		23,969					6,996		
	6/30/1968	526,632			287,749	238,883		45.4		499,790		26,842					5,793		
	6/30/1969	593,400			307,612	285,788		48.2		567,962		25,438					6,620		
	6/30/1970	633,698			364,293	269,405		42.5		606,894		26,804					8,145		
	6/30/1971	726,919			412,683	314,236		43.2		693,974		32,945					8,703		
	6/30/1972	885,562			499,272	386,290		43.6		854,599		30,963					9,244		
	6/1/1972 to 10/21/1972	294,958	4,179,917				1,728,451		44.5	294,958	4,012,956	8,584	214,321				3,232	(48,733)	
Gresham Community Hospital Gresham, Ore.	**16½ mos. ending** 10/31/1972	266,047	266,047		233,840	161,031	161,031	60.53	60.53	223,165		28,776	28,776	14,106 ("other")		14,106			
Bess Kaiser Hospital Portland, Ore. and Permanente Clinics	**Calendar** 1961	250,720			138,454	112,265		44.78									57,100		
	1964	383,340			308,845	74,494		19.43									64,800		
	1966 (clinics only)	271,819										271,819					130,300		
	1967 (clinics only)	340,095										340,095					186,300 (total)		
	1968	820,446		658,160	658,160					435,025			611,914				208,900		
	1969	957,135		781,690	781,690												258,100		
	1970	1,252,014		1,036,240	1,036,240												315,100		
	1971	1,447,575		1,291,359	1,291,350	558,167		38.55									373,782		
	1972		5,723,144				744,926		35.8								414,069		
																	373,626		
Holladay Park Hospital Portland, Ore.	**Year ending** 6/30/1967	247,754			111,848	111,848		45.1		205,481		14,801		27,472					
	6/30/1968	274,685			141,979	132,706		48.3		233,841		14,009		26,835					
	6/30/1969	302,602			170,634	131,968		43.6		258,307		13,379		30,916					
	6/30/1970	300,974			178,162	122,812		40.8		254,382		13,097		33,495					
	6/30/1971	305,585			204,976	100,609		32.9		261,996		13,422		30,167			842		3,894
	6/30/1972	318,337	1,749,937		204,576	113,761	713,704	35.7	40.78	275,417	1,489,424	12,552	80,540	30,368		179,253	693	(7,391)	3,497 (7,391)
Physicians and Surgeons Hospital Portland, Ore.	**Fiscal** 1967	238,466			167,891	70,575		29.59		189,627		48,839		(included					
	1968	250,477			161,842	88,635		35.38		200,194		50,283		in "outpatient"					
	1969	298,695			187,598	111,097		37.19		247,489		51,206		sales)					
	1970	367,851			214,510	153,341		41.68		314,843		53,008							
	1971	366,367			226,635	139,732		38.14		328,077		38,290							
	1972	389,862	1,911,718		144,845	144,845	708,225	37.2	37.0	354,582	1,634,812	35,280	276,906						
Portland Adventist Hospital Portland, Ore.	**Calendar** 1965									291,720				10,367					
	1966	322,157			256,786	65,371		20.3		309,801				12,356					
	1967	367,110			245,461	121,648		33.1		357,236				9,873					
	1968	424,981			242,747	182,233		42.9		411,423				13,557			983		
	1969	447,608			255,429	192,178		42.9		426,483				29,124			1,444		
	1970	497,440			279,588	217,851		43.8		475,401				22,039			1,443		
	1971	492,550			293,015	119,535		48.6		468,662		23,887					2,049		
	1972 (9 mos.)	379,667	2,931,513		223,095	156,572	1,055,388	41.2	38.7	362,288	3,103,014	17,910	41,797			89, 16	2,506	(8,425)	
Portland Osteopathic Hospital Portland, Ore.	**Calendar** 1967	197,900			190,761	7,139		3.6											
	1968	203,931			189,420	14,511		7.1											
	1969	190,143			134,831	55,312		29.0											
	1970	217,634			124,356	93,278		42.8											
	1971	245,762			139,994	105,768		43.0									13,467		
	1972 (10 mos.)	215,411	1,270,871		125,415	89,996	366,004	41.7	28.8					3,554	4,134	7,688	11,923	(25,390)	
Providence Hospital Portland, Ore.	**Calendar** 1966	339,678																	
	1967	416,463								401,693		14,470		(estimated					
	1968	435,378								420,232		15,146		at 50% of					
	1969	458,651			302,163	133,783		29.1		428,136		30,514		outpatient					
	1970	526,908			314,430	176,079		33.4		477,598		49,309		sales)					
	1971	640,286			337,990	254,762		39.8		579,838		60,447							
	1972 (9 mos.)	582,798	3,400,162		291,197	250,255	814,879	42.9	36.9	589,391	2,896,888	51,150	221,036						
St. Vincent Hospital Portland, Ore.	**Calendar** 1966	419,815								409,578		10,236							
	1967	502,390								491,433		10,957							
	1968	541,831		155,711	283,180	240,584		44.4		521,218		20,612		18,067					
	1969	606,904		177,822	310,106	277,872		45.8		585,300		21,603		18,926					
	1970	594,760		194,386	341,030	232,939		39.2		569,321		25,438		20,791					
	1971	630,282		198,896	388,662	216,650		34.4		598,887		31,394		24,969					
	1972 (9 mos.)	545,262	3,841,244	153,300	269,844	287,162	1,255,207	52.7	43.0	499,981	3,675,718	45,280	165,520	32,256		115,009			
Tuality Community Hospital Hillsboro, Ore.	**Year ending** 9/30/1966	62,590			34,712	27,878		44.5											
	9/30/1967	72,011			38,853	33,157		46.0											
	9/30/1968	89,457			51,770	37,686		42.1											
	9/30/1969	102,820			58,864	43,956		42.7		98,321		4,495							
	9/30/1970	178,057			70,757	107,299		60.2		170,371		7,685							
	9/30/1971	190,620			71,918	118,703		62.2		181,430		9,190							
	9/30/1972	205,275	900,830		98,839	108,492	477,172	59.8	43.0	195,891	646,013	9,383	30,753						
Willamette Falls Community Hospital Oregon City, Ore.	**Year ending** 7/31/1965	54,007																	
	7/31/1966	64,353																	
	7/31/1967	80,720																	
	7/31/1968	94,188																	
	7/31/1969	84,496																	
	7/31/1970	82,519																	
	7/31/1971	159,07;																	
	7/31/1972	263,274	882,628																
Willamette Methodist Convalescent Center Milwaukie, Ore.	**Year ending** 9/30/1967	36,211			36,137	74		0.2											
	9/30/1968	52,997			51,053	1,944		3.7											
	9/30/1969	56,809			50,675	6,125		10.7											
	9/30/1970	63,205			55,111	8,094		12.8											
	9/30/1971	63,833			52,042	10,883		17.0											
	9/30/1972	69,944	342,999		63,260	6,684	33,804	9.5	9.85										
			$32,792,997				$10,155,165						$2,037,420			$670,002			

2

COLUMBIA RIVER

N

WILLAMETTE RIVER

GRESHAM

122ND

82ND

MULTNOMAH COUNTY

CLACKAMAS COUNTY

123 CLOSURES.
11 OUTSIDE THE SPHERE OF INFLUENCE

METRO-PORTLAND PHARMACIES

- PRESENT OPERATING RETAIL PHARMACIES
- CLOSED PHARMACIES
- KAISER PHARMACIES
- HOSPITAL PHARMACIES

3

COLUMBIA RIVER

N

VILLAMETTE RIVER

KILLINGSWORTH

FREMONT

VAUGHN

BURNSIDE

BARNES

STARK

HAWTHORNE

DIVISION

POWELL

FOSTER RD

BEAVERTON HILLSDALE HIGHWAY

TALOMA

MULTNOMAH COUNTY

CLACKAMAS COUNTY

82ND

122ND

181ST

242ND

GRESHAM

123 CLOSURES.

11 OUTSIDE THE SPHERE of INFLUENCE

METRO-PORTLAND PHARMACIES

- PRESENT OPERATING RETAIL PHARMACIES
- CLOSED PHARMACIES
- KAISER PHARMACIES
- HOSPITAL PHARMACIES

4

COLUMBIA RIVER

N

WILLAMETTE RIVER

LOMBARD

KILLINGSWORTH

FREMONT

BROADWAY

BANFIELD FWY

SANDY

BURNSIDE

STARK

HAWTHORNE

DIVISION

POWELL

FOSTER RD

122ND

TACOMA

MULTNOMAH COUNTY

CLACKAMAS COUNTY

82ND

BEAVERTON HILLSDALE HIGHWAY

181ST

GRESHAM

242ND

METRO-PORTLAND PHARMACIES

- PRESENT OPERATING RETAIL PHARMACIES
- CLOSED PHARMACIES
- KAISER PHARMACIES
- HOSPITAL PHARMACIES